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UNSERVED CONSUMERS' PERCEPTIONS OF CONSUMING AND POTENTIAL CUSTOMERSHIP IN DIGITAL HEALTH CARE SERVICES: STUDY IN THE CONTEXT OF INTERNET THERAPIES

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Abstract

The culture of health care services is going through changes, resulting in the continuous emerge of new health-related services. Also, the discourse of health has reached new dimensions, many of which are traditionally more familiar to the consumer markets. Thus, traditional roles and relationships of health service actors are changing, and the consumers are allocated with neoliberal assumptions of responsible, entrepreneurial citizens, who are able and willing to actively participate in co-creation of their state of health through digital service channels. The purpose of this study is to examine how these phenomena are perceived among currently underserved mental health consumers and whether they perceive the current services markets to meet their needs as consumers. The research is conducted in the context of internet therapies offered in Finland. This research relies on the existing literature on health care services, digital health consumption and consumer behaviour literature. As mental health can be defined as a delicate topic in society, mental health consumers are examined in the light vulnerable consuming literature.

This research is qualitative in nature and relies on the methodological assumptions of interpretative phenomenological analysis (IPA). The data of this study is collected by semi-structured in-depth interviews and written texts from potential users of internet therapies. The data is further analyzed by the tradition of IPA research and data-based content analysis, in order to interpret the relation between the lived experiences of individuals and the current phenomena occurring in health servicesscape.

This research increases our understanding on how consumers perceive customership in the health services market, and how they would perceive their role as customer in self-guided online mental health services. Finding both convergence and divergence with existing literature, this study shows that although consumers recognize the change in the health services culture, they do not perceive the current trends to be applicable to consuming mental health. This study suggests that there are two different contexts of digital health consuming, and that digitalization does not fully explain the phenomenon. Moreover, this study reveals that consumers have primary and secondary needs for mental health services and that many forms of digital services are perceived to prevent the fulfilment of the primary needs. Although consumers perceive digitalized mental health services as a possibility to serve the secondary needs, they perceive them as disempowering rateher than empowering until the primary needs are met. Digital services are perceived to lack adequate human attendance and to require too much autonomy. Thus, this study suggests that, in order enable the empowering possibilities of digital solutions, strategies to serve these customers must be developed.

The findings of this study contribute to consumer behaviour and services research literatures by increasing our understanding on the phenomena of current health discourse, consumer empowerment and consumer vulnerability in the context of health services. As this research also increases our understanding of the consumer perceptions and behaviour in the market, the findings may also be considered in managerial decision-making, like in services development and communication of digitalized mental health services.

Keywords digital health care services, consumer behaviour, consuming in health servicesscape, internet therapies, vulnerable consumers, mental health

Tekijä Henriikka Seittu

Työn nimi Palveluiden tavoittamattomissa olleiden kuluttajien näkemyksiä kulutuksesta ja asiakkuuden mahdollisuudesta digitaalisissa mielenterveyspalveluissa: Tutkimus nettiterapioiden kontekstissa

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Tiivistelmä

Terveyspalveluiden kenttä käy läpi muutosta, kun uusia, kuluttajien jatkuvasti saatavilla olevia digitaalisia palveluita ilmestyy perinteisten palveluiden rinnalle. Käsitys terveydestä on markkinositunut ja ulottunut koskemaan uusia, aiemmin kuluttajamarkkinoilta tuttuja ilmiöitä. Kehityksen seurauksena terveyspalveluihin osallistuvien osapuolten väliset suhteet ja perinteiset roolit ovat muuttuneet. Kuluttajiin kohdistetaan uusliberalistisesta talousajattelusta juontuvia oletuksia, joiden mukaan asiakkaat toimivat vastuullisen ja yritteliään kansalaisen tavoin; he ovat kykeneväisiä ja halukkaita osallistumaan terveydentilansa vaikuttamiseen digitaalisten kanavien välityksellä. Tämän tutkimuksen tarkoituksena on tutkia, kuinka perinteisten terveyspalveluiden tavoittamattomissa aiemmin olleet kuluttajat mieltävät palvelukentällä tapahtuneen muutoksen, ja kuinka he näkevät nykyisen palvelutarjonnan vastaavan tarpeitaan. Tutkimus on toteutettu Suomessa tarjottavan mielenterveyspalvelun, nettiterapioiden, kontekstissa. Nojaten olemassa olevaan terveyspalveluiden, digitaalisen kuluttamisen sekä kuluttajan käyttäytymisen kirjallisuuteen, tutkimus tarkastelee mielenterveyspalveluiden asiakkaita heikossa asemassa olevina kuluttajina.

Tutkimus on luonteeltaan kvalitatiivinen ja pohjautuu tulkitsevaan fenomenologisen analyysiin. Tutkimusaineisto on kerätty puolistrukturoitujen syvähaastattelujen sekä kirjoitettujen tekstien muodossa nettiterapioiden potentiaalisilta asiakkailta. Haastatteluiden analyysissa seurattiin tulkitsevan fenomenologisen analyysin käytänteitä ja kirjoitettujen tekstien analyysissa aineistolähtöistä sisällönanalyysia. Analyysissa tulkittiin terveyspalveluihin liittyvien yksilön kokemusten ja laajempien ilmiöiden välisiä suhteita.

Tutkimus syventää ymmärrystämme siitä, miten kuluttajat mieltävät kuluttajuuden terveyspalvelumarkkinoilla, sekä millaisena he näkisivät roolinsa verkkopohjaisten mielenterveyden omahoito-palveluiden asiakkaina. Tutkimus osoittaa, että kuluttajat tunnistavat terveyspalvelukentällä tapahtuvat muutokset, mutta he eivät miellä näitä muutoksia mahdollisiksi soveltaa mielenterveyteen liittyvään kulutukseen. Tutkimuksessa selviää, että kuluttajat kokevat terveyspalveluiden kuluttamisen polarisoituneena ilmiönä. He tunnistavat sekä palveluita, joissa asiakkaan voidaan olettaa toimivan kuluttajan tavoin, että palveluita, joissa he eivät näe tällaista toimintaa mahdollisena. Tutkimus osoittaa, että kuluttajilla on ensi- ja toissijaisia tarpeita mielenterveyspalveluille ja että he mieltävät digitaalisten palveluiden oletettavasti vaikeuttavan ensisijaisten tarpeiden täyttymistä. Toisaalta tutkimus osoittaa, että digitaaliset palvelut nähdään voimaannuttavana mahdollisuutena, mikäli ensisijaiset tarpeet ovat täyttyneet. Ensisijaisten tarpeiden täyttäjinä digitaaliset palveluiden oletetaan olevan liian autonomisia ja epäinhimillisiä.

Tutkimus laajentaa ymmärrystämme siitä, millaisena mielenterveyskuluttajat mieltävät roolinsa ja kulutuskäyttäytymisensä omahoitoon pohjautuvissa verkkopalveluissa. Tutkimustulokset täydentävät kuluttajan käyttäytymiseen ja palveluiden tutkimukseen liittyvää kirjallisuutta tuomalla näkökulmia nykyisen terveysdiskurssin, kuluttajan voimaannuttamisen ja heikossa asemassa olevien kuluttajien ilmiöihin.

Avainsanat digitaaliset terveyspalvelut, kuluttajan käyttäytyminen, terveyspalveluiden kulutus, nettiterapiat, heikossa asemassa olevat kuluttajat, mielenterveys

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1 INTRODUCTION

The culture of health care services is going through turbulent changes as it is trying to respond to ongoing internal and external processes, like the increasing amount of data and knowledge, the personalization of health care services and medicine (see e.g. McColl-Kennedy, Snyder, Elg, Witell, Helkkula, Hogan and Anderson, 2017) and the rising economic burden to states, for example due to ageing of people and widening of health inequality (WHO, 2013). These changes can be seen for example as an emergence of new health consuming markets and general health care policies that emphasise recovery orientation, outpatient treatments and patient empowerment through digital channels (Newman, O'Reilly, Lee, Kennedy, 2015; WHO, 2013). Currently, services are perceived as complex networks in which the health is co-produced between various actors. All this is challenging the tradition of profession-based hierarchies in services and thus the roles and relationships of different actors of health care services (see e.g. Black & Gallan, 2015; McColl-Kennedy, 2012, 2017).

From the aspect of health care service customer, who traditionally have been recognized as passive actors, as patients, these changes signify possibilities and requirements to more actively engage with the co-creation of the service activities concerning their own health (Ostrom, Parasuman, Bowen, Patricio & Voss, 2015; McColl-Kennedy et al. 2012, 2017). Due to the emergence of new markets, health care services have also widened to cover areas that previously were not considered to be part of health care discourse, and found new ways to produce these services, e.g. through digital devices (see e.g. Black & Gallan, 2015, McColl-Kennedy et al. 2017). Thus, ideally those customer segments, which have not previously found their spot in the marketplace, might be now served.

In this study, aspects of services research and consumer behavior research are looked at. Many fields have publisher scientific articles during the last couple of years. On one hand, they are mainly on done in wellbeing context. But on the other hand, the other hand, the research made in more traditional health service contexts is criticized of paying too much attention to chronic diseases, which means, that the diversity of different diseases and customer groups is not researched much enough (Askegaard & Schneider-Kamp 2019). Moreover, in this research, the positive effects and possibilities, due to digitalization and the phenomena of patient empowerment has been emphasised a lot. The research is criticized to bypass the facts that also in these services the consumer usage remains low, the level of drop out is high, and in general, the service needs are not met often enough.

Turned in numbers, globally, the cumulative impact of mental disorders in terms of lost economic output is forwarded to exceed US$ 16,3 million between 2011 and 2030. Even in high income countries 35-50 % of people with severe disorders do not receive help (WHO, 2013). In Finland, the trend is similar. According to government's analysis, assessment and research activities publication (89 / 2017) there are problems in integration, access and timeliness of mental health care services (Wahlbeck et al. 2017). In 2017 depression was the biggest singular reason for disability pensions (Eläketurvakeskus, 2019), for an early retirement at the middle-age of 45 (Eläketurvakeskus, 2018).

To conclude, more research to solve the paradox of health care services is needed. In this research, the phenomenon is researched from the viewpoint of consumers who previously have been underserved, but ideally could be better served through these digital health care services. Because of the economic nature of my research, I approach these users as consumers, i.e. economic actors in the services markets. To contribute the literature, the target consumers are the users of mental health services, because they are one of the most under researched groups (see e.g. Danaher & Gallan, 2016). To further define, this research is contextualized to potential customers of internet therapies, offered in Finland. The purpose of this study is to find out what these consumers think about the development of health services and to see whether they could perceive themselves as customers of these services. Further defined, I aim to uncover how the knowledge and understanding of consuming mental health care services is built and what kind of perceptions people have towards the development in general. Upon these factors, I aim to analyse how their understanding appears in their consumer behaviour, such as their consuming habits and results, and whether the needs of these potential consumers would be met in the marketplace. Thus, my other contribution to the literature is to gain information of the drivers and consequences of health care customer behaviour among mental health consumers.

My research question is:

How do potential consumers, who are at the moment underserved in mental health care services, perceive the possibility for customership and consuming in new digital servicescapes of mental health?

2 LITERATURE REVIEW

The literature review of this study consists of literature on health care services, digital health consumption and consumer behavior. However, because the context of this study is in internet therapies, all these topics are further discussed with research findings made in the field of mental health. This mixture of literature is deployed because there is hardly literature focusing on purely consumption and behavior in the digital mental health care context.

2.1 Services research in health care

Today, services are considered in the literature as broad and complicated multi-actor networks, in which the value is co-created in multiple service encounters by different unknown and known actors (Sangjorgi, Patricio and Fisk, 2017 p. 50-55). In these networks, the roles and boundaries between different actors has changed and even become blurry. Neither are all interactions conscious nor directed by the service provider. (Sangjorgi et al. 2017 p. 51).

Health services of today are no exception. The change of the service environment has also had an influence on the traditional service actor roles and relationships in health care (Askegaard & Schneider-Kamp, 2019). That process, also called as modernization of health care, is more or less visible in health policies, public debates and in institutional level in practices of health care services (e.g. Askegaard & Schneider-Kamp, 2019). Moreover, the future of the health care sector is considered to be dependent on efficiency and productivity of the patient-centered services, that are built on features like easy customer access and customer inclusion (Black & Gallan, 2015).

So far, it has been argued that the customer involvement in health-related contexts is still far from enabling the delivery of services that would reflect the interests of the users. In the dialogue with professionals, customers are still not situated as noteworthy voice. On the contrary, dismiss of the customers' role still exist. (Cowden & Singh, 2007). In fact, Porter (2010) argues, that in health care, the value is still defined based on science of medicine, skills of the service provider and possibilities of the production. These factors, however, do not automatically equal to viewpoint that customers' value would be in the center of the care (Porter, 2010). Thus, services research offers an important viewpoint to benefit from the possibilities and to understand the changes in health care of today (Danaher & Gallan, 2016).

To enhance this changing collaboration and communication, both understanding of the services logic and the health care environment is needed. To analyze the services, we need to understand how the customers' networks are structured in the specific environment the services are produced and consumed in. Thus, we need to recognize all the complex and hierarchical settings inside the organizations and the sheer scale, variety and complexity of the needs to which the services are produced in. (Black & Gallan, 2015). For example, Danaher and Gallan (2016) point out that as organizations health care services are often arranged based on factors like disease state or patient type, which causes problems, for example, in communication about the treatment of patients who are in a need of many different services.

Lastly, we need to understand the nature of health as a context of economic exchange, because the logics of health care services differ from the logics of traditional service markets in many ways. In health care, where the resources are limited, increase in the supply of the services tends to increase also the demand of the services. Thus, in producing and consuming health, there are many specific characteristics, like many conflicting emotions and the risk of negative externalities, involved. (Sintonen & Pekurinen, 2006 p. 44-51). Also, notable is that the demand for the services comes from people who are more or less fragile, vulnerable and dependent (Robert & Macdonals, 2017 p. 117). That then again means, for example, that the dependency of different diseases and consumer behavior must be recognized in applying different services logics (Prigge et. Al 2015). In order to understand these specialties in the context of consumption, aspects of discourse around health, digitalization in health care and consumer empowerment are now discussed in this literature review.

2.1.1 The rise of healthism in the market place

The notable increase in health conversation is located to have begun in the mid 1980s. Health has been a key topic in health policies and promotion in governmental, media and corporate levels. (Ayo, 2012). As one dimension of the development, can be seen the continuous emerge of new markets for health-related goods and services (Dean, 2008). The phenomenon, also discussed as commodification of health market (see e.g. Ayo, 2012 or Crawford, 2006) or as "neoliberal health landscape" (Fotopoulou & O'Riordan, 2017), as health is discussed more and more in new health-related, wellness and fitness contexts and industries. According to Crawford (2006), the development can be seen as raising of "healthism", a particular form of "bodyism". "Healthism", Crawford (2006) explains with help of Dutton's (1995, p. 273) definition of "bodyism", in which "the hedonistic

lifestyle meets the preoccupied ascetic practices that aim to achieve or maintenance the state of health, fitness and youthfulness".

The core of the change is based on the idea that the consumers of health equal to the neoliberal assumptions of responsible, entrepreneurial citizens (Crawford, 2006). In consequence of that, they are also the cause and the solution for their health circumstances and solutions. They react logically towards provided guidance of healthy living and respond it with consuming time, money and personal resources to their health, which is seen as both lucrative investment and as obligation imposed by citizenship. (Ayo, 2012). Kristensen et al. (2016) argue, that for these individuals, health is like a "DIY framework of healthism", a project, that is possible for each to monitor. Similar notions of change in health demand have been made in health economics research. According to, for example, Dong (2013) and Doiron et al. (2008), the demand for private sector health services is signalizing a change towards resembling the demand in services market consumption. As a consequence of that, the demand of health seems to be more loosely linked to the actual medical need (Dong, 2013).

In these new health consumptionscapes, consumers have become more active in defining the dimensions of health. That demonstrates a change because traditionally health has been defined by the health care professional and it has focused to people with medical conditions. (Ayo, 2012). Consumers, however, are exposed to the conflicting notions of healthism, through which they navigate with a template of "healthist self". The template is formed between the expectations of the traditional medical authorities and the social ideal of health, that is offered, for example, by private health actors and other consumers. Especially, that is made possible through the digital consumptionscapes, where the health information is affordable for everyone. (Kristensen et al. 2016). As a consequence of that, consuming of health has transformed towards objectified and standardized market exchange, where individuals can control their purchase. For these new health consumers, health has become a consumable identity marker in social battlefield. (Kristensen et al. (2016).

This has also led to skepticism towards traditional sources of health information. Kristensen et al. (2016) talk about the division of expert and non-experts. In this division, health is not only defined by medical experts but also by neoliberal consumer markets. That notion is also supported in the research of Fox and Ward (2006), who recognize that although the health identity of individuals is still partly based on medical knowledge, people are also engaged to alter their physical body to correspond to culturally acceptable norms. Moreover, Fox and Ward (2006) found that not only medical but also a lot of information about healthy lifestyle was shared in the health labelled

conversation of consumers. Moreover, Burrows, Nettleton, Loader and Muncer (2000) argue that the emerge of new medias, that are offering new forms of self-help and social support platforms, has changed the ways how people communicate and share support around health without the involvement of health professionals.

As a consequence of that, things we consider as health has spread into new areas of life. The whole concept of health has become more complex and reached diverse perceptions, many of which are more familiar from the by the ideology of consumer markets (Kristensen et al. 2016). No shared understanding of the construction of health is reached but there are some recent conceptualizations of the phenomenon. One of the conceptualizations of health in the digital health consumptionscapes is offered by Cavusoglu and Demirbag-Kaplan (2017). They recognize that the discourse of health is clustered around 4 F's: food, fitness, fashion and feelings. According to Cavusoglu and Demirbag-Kaplan (2017), these four dimensions can be further categorized by their degrees of representation on commodification (how the meanings are reflected through commodities) – communification (how generating meanings is made through interacting in communities) and bodily - spiritual well-being aspects, representing the more traditional way of dividing the dimensions of health. In their research, Cavusoglu and Demirbag-Kaplan (2017) found, that the most health associations were presented in categories that has the linkage to bodily dimension of health: in food and fitness clusters. Instead, in the spiritual categories, fashion and feelings, the concept of health was not associated as much. From the aspect of my research, interesting also the notion of Cavusoglu and Demirbag-Kaplan (2017), that in the categories around spiritual health, the discussion is focused only on positive things, like showing gratitude for life and maintaining good health with the help of through positive feelings.

2.1.2 Patient or customer? Listening and empowering the customer

Other central dimension of the modernization is the idea of empowerment of the customers. As example, to successfully emphasis the current evolution of the broadening customer role in health services, we need information of the needs of these service receivers as customers, not only as patients. Also, to create a culture of "co-creation" we need to understand the background and the characteristics of the specific environment the services are created in. (see e.g. Robert & Macdonald, 2017 p. 117).

With the term customer empowerment, it is referred to a set of self-determined behaviors based on patients' individual needs. It is used to develop the patients' autonomy and competence with their disease. (Prigge et al. 2015). In the research, a concise conceptual definition is lacking. That is why

the phenomenon is discussed with set of overlapping terms, like client, customer or patient empowerment, participation, activation, enablement, engagement or involvement, depending on the facets in which the phenomenon is considered in (see e.g. Ouschan, Sweeney and Johson, 2000 or Fumagalli et al. 2015). In my research, I refer the term with using both consumer empowerment and patient empowerment. Despite the many names of the phenomena, there is a common understanding that it is one of the key components in mainstream patient-centered approach of health care practices (see e.g. Prigge et al. 2015 or Fumagalli et al. 2015). Also, it is the current interests of many research fields, from medical sociology to health economics and to health policies research (Ayo, 2012).

To understand the theory behind the phenomenon, few conceptualizations are discussed. Firstly, in their early review of the multidisciplinary literature, Ouschan et al. (2000) recognize three core dimensions on the conversation around patient empowerment. According to them patient empowerment is discussed both as patient participation, when referred to the level to which the decision-making is relying on the input of the consumer and as patient control, when referred to the level in which patients take control of their health state. Moreover, it discussed as patient education when referred to the level of patients adopt medical knowledge. Prigge, Dietz, Homburg, Hoyer and Burton (2015) have contributed these three dimensions of Ouschan et al. (2000). They further classify the dimensions of information search and knowledge development to signify patient's need for competence. The dimension of decision participation then again, they define to signify patient's need for autonomy. As behavior, the need for competence comes out as need for information search and knowledge development. Instead, the need for autonomy comes out as need to participate in decision making (Prigge et al. 2015). Furthermore, Askegaard and Schneider-Kamp (2019) has recently contributed the dimensions of Ouschan et al. (2000) with fourth dimension: patient autonomy. With patient autonomy, Askegaard and Schneider-Kamp (2019) refer to the extension to which the action of the patient is dependable of health professionals. They recognize it as both behavior with and without the involvement of health professionals. Moreover, they argue that the patient autonomy is dependent on the possibility to use technology.

Other, quite recent conceptualization of the dimension of customer empowerment is offered by Fumagalli, Radaelli, Lettieri and Masella (2015). They define customer empowerment "as the acquisition of motivation (self-awareness and attitude through engagement) and ability (skills and knowledge through enablement), that patients might use to participate in decision-making and consequently create an opportunity for higher levels of power in their relationships with professionals". Fumagalli et al. (2015) conceptualize customer empowerment to a framework, that

includes three different interpretations. Firstly, it can be interpreted as an emergent state, referring to the state that makes patients willing and able to take active role in their care. Secondly, it can be interpreted as a process, portraying the change through which the patients turn the knowledge, skills, attitudes and self-awareness to self-directed behavior change. Thirdly, it can be interpreted as a participative behaviour, which is a state in which these gained recourses will be concretized in real-life contexts. To compare the definitions, for example, between Fumagalli et al. (2015) and Askegaard and Schneider-Kamp (2019) we can note that the first recognizes the phenomena as more of an external process from the patient. The latter, instead, views it as tactical interactions with the social environment of the patients.

However, what is more important from the aspect of my research, is how the customer empowerment effects to the consumer behaviour. As it' s positive outcomes, customer empowerment is linked to improved medical outcomes, that are thought to save the scarce resources of health care sector (Chatzimarkakis, 2010) and to offload work from the health professionals to customers (Salmon & Hall, 2003). As a result of the latter, customers would take some of the responsibility of the "unnecessary" demand on health services by increasing the level of their self-care (O'Cathain, Goode, Luff, Strangleman, Hanlon and Greatbatch, 2005). Moreover, customer empowerment has been found to raise opportunity to enhance to the multidisciplinary dialogue and to foster networked planning in health care services (Chatzimarkakis, 2010). Also, Laverack (2005) has noticed the difference between individual patients' and patient communities' empowerment. In a case of single person's empowerment, the gains can be seen in self-efficacy and self-esteem. In the action of communities, instead, the gains can be seen more as a raise of consciousness (Laverack, 2005).

However, in order to fully achieve these positive outcomes as concrete practices in everyday life, Chatzimarkis (2010) points out that the patients need to internalize their new role. This is also one of the reasons why more understanding of the customer experience in health services is needed. For example, we still lack understanding of the drivers and consequences of customer empowerment. Hoewever, some research has been made by Prigge et al. (2015). They suggest, that customer empowerment effects positively on therapy compliance. According to them, customer empowerment seems to be either positively or negatively affected by the involvement level on one's health, the level of self-efficacy and by the acceptance of health care professionals' authority. However, in these processes, the drivers affecting on patients' autonomy seem to have stronger effect on patients with less severe diseases. Also, among patients suffering serious diseases the patient empowerment seems to somewhat raise their need for competence but not to stimulate their need for autonomy. Moreover,

an interesting detail, found by Prigge et al. (2015), is that the acceptance of physician authority effect negatively to all of the three dimensions of patient empowerment and their outcomes. However, to be able to encourage consumers to empowerment behaviour, more research about the working-logics of the phenomenon must be done.

Lastly, also some critique has been made. Especially, among the researchers on different social research, criticism is often pointed to the way how in practice level health and illness are perceived as genetic, medically defined phenomena. As a consequence of that their ties to social, cultural and psychological levels of human existence are dismissed (e.g. Fox & Ward, 2006). Also, the context-dependence of the empowerment is raised forth by e.g. O'Cathain et al. (2005), who in their research in online telehealth services, found out that people experiencing pain, ill or in negative feelings might value more being cared for than being empowered. They also found out that the perceptions of what is necessary and unnecessary in health services varied between the patients and the service providers. Furthermore, e.g. Spencer (2014) and Schulz and Nakamoto (2013) both argue that undertaking the responsibility of self-care is too uncritically considered to lead to the person being empowered. They also argue that empowerment is too much considered to unproblematically result in positive health outcomes. An example of that kind of results was achieved by Jayanti and Singh (2010) who argue that patients might not be interested to collect health information after some point because they might feel overwhelmed by the amount of information. Moreover, they found that the empowerment might turn to challenging behavior towards expert's guidance, not to improved health outcomes.

2.1.3 Digitalization as the enabler of modernization

As third aspect to discuss, I raise the role of digitalization in the changes of health care. That is, because in health care services, technology has increased the possibilities to interact (Ostrom, et al. 2015). Additionally, digitalized health care systems are proposed to be one of the solutions in facing the problems of health care services. For example, digital services are idealized to lower access to treatment because customer groups, that has traditionally been underserved, because of for example geographical distance, could be now reached with digital connection. (Ekeland & Bowes, 2010).

So, much of the customer empowerment is located to happen in the digital environment, also called as practice of "eHealth", "digital health", Medicine 2.0" or "Health 2.0" (see e.g. Lupton, 2016). Digitalized information systems, mobile applications, implanted biosensors and wearables have seen to allow a regular and quick access to all people to take control of the tasks that were traditionally

carried out by the health care professionals (see e.g. Lupton, 2016). According to Fox and Ward (2006) interaction in digital environment is made both to participate actively in to treating the medical conditions and to participate in to the discussion in health-related forums linked to "lifestyle" conditions, like weight management. In the digital consumptionscapes, Lupton (2013) further term consumers as "digitally engaged patients", referring to people, who engage in the processes of self-care and self-monitoring and achieve the empowerment through technology. Thus, in the digital practices, consumers are not only loaded with presumptions of only being rational and motivated actors but also being equipped enough to participate in (Oudshoorn, 2011).

What is important from the aspect of my research, is what we know about how the digital consumptionscapes effect on health consumer roles or behavior. That is, however, one of the topics that are not that much discussed in the literature concerning mental health consumers yet. Thus, to be able to assess the consumer behavior in different health care sectors, literature from other health services is brought to this literature review. As example, in their research of emerging of health identities among people and patient using medical technologies, Fox and Ward (2006) identified a range of different types of consumer types. These consumer types ranged from resisting (anti-)consumers, who opposite the medical model of disease and treatment, to expert patients, who took an active role in managing their health taking, either supporting mainstream medical advice or emphasizing healthy lifestyle. Fox and Ward (2006) also found, that these identities reflected to consumers' relations to society, that is currently driven by consumer orientation and media saturation.

In the research, both empowering and disempowering effects on customers' behaviour has been raised out. However, we know more about the empowering effects because most of the research has focused to this side of the phenomenon (Lupton, 2013). For example, in individual level, the digital environments have been seen to offer a possibility to avoidance of face to face contacts and a distance from the medical surveillance (Andreassen Trondsen, Kummervold, Gammon and Hjortdahl, 2006). In social level, online groups, for example, have found to offer a safe "third place" for vulnerable consumers (Parkinson, Schuster, Mulcahy and Taiminen, 2017). However, e.g. Lupton (2013) argues, that the discourse around the effects on consumer behavior is focused on techno-utopian assumptions, and there exists dismiss of the ambivalence and complex experiences of the consumers. In her research, Lupton (2013) for example found appearance of negative emotions and resistance towards technologies. That she explained by findings that showed how health technologies were perceived to add the burden of self-care and the pressure of the invisible work. Thus, as mental health consumers

can be seen to represent a vulnerable consumer group, more knowledge about this field of consumer behaviour is discussed below.

2.2 Services research in mental health care

As become apparent, the literature of consumer behavior in health services lack of research among mental health customers. However, some research of health care modernization has been made in the field of mental health services. In addition, more research has been made with the focus on vulnerable consumers, which can include mental health consumers. To add up, what we know about the phenomenon under this research, firstly, the previously discussed trends of health care are discussed from the viewpoint of mental health. Secondly, literature of vulnerable consumption is discussed.

2.2.1 The trends of the health care modernization in the mental health servicesscape

Firstly, the trend to digitalize health care has also brought many online services to mental health sector. They can be further categorized based on their properties, such as real-time – time-independent usage, or whether they correspond to traditional treatments and are complemented with digital form of communication (e.g. video). They can also be based on self-help (e.g. learning environments) (see e.g. Barak & Grohol, 2011, Musiat, Goldstone and Tarrier, 2014). As an integrative categorization of digital mental health services Barak and Grohol (2011) categorize the online interventions under five categories: online counseling and psychotherapy, psychoeducational websites, interactive, self-guided interventions, online support groups and blogs and other types of online interventions. To framework this research to this categorization of Barak and Grohol (2011), internet therapies represent most the category of interactive, self-guided intervention. These interventions Barak and Grohol (2011) define as structured and self-guided online self-help programs, that are usually based on, for example, cognitive-behavioral literature and interactive exercises.

However, the field of these mental health interventions is mostly researched from technological or medicine perspectives and customer perspective is even scarcely examined. More research seems to be needed because, for example, Musiat et al. (2014) found that in deciding whether to use the service or not, the experience of the helpfulness of the services was perceived to bemore important than any factors related to functional properties. In line, Gammon, Strand and Eng (2014) and Taiminen and Saraniemi (2018) have argued that to benefit from the self-creation possibilities of the technology, mental health customers would need assistance and proactive encouragement. The need for guidance

to adopt the new roles of the customer seems natural, because mental health care services have traditionally been based on reactive, consultative and disorder-focused cultures (Gammon et al. 2014).

Secondly, to understand mental health services as a subfield of health care, some characteristics of it need to be taken into consideration. One of the phenomena recognized in the behavior of mental health users is the customers' feeling of ambivalence towards the services. According to Berry and Bendapudi (2007), health services are good example of services, that are needed but not necessarily wanted. As behavior, that kind of experience is noticed to cause, for example, avoision to search information about the services, reluctancy to seek help and high drop-out levels of the treatments (see e.g. Berry & Bendapudi, 2007). The behavior of people suffering from mental health problems, is often discussed to origin from the experience of stigma (see e.g. Corrigan, 2014). Stigma has, for example, found to diminish self-esteem of a stigmatized person. Also, it has seen to cause avoidance of opportunities, that could include social disapproval through stereotypes, prejudice or discrimination. Moreover, stigma has seen to build barriers for people to seek help, because it causes for example fears of mental health problems coming into the knowledge of unwanted facets, like employers. (See e.g. Corrigan, 2014). In the light of these findings, it is considerable to ask, how mental health is perceived to be located in the current discourse around health.

Thirdly, to assess the empowerment of mental health customers, some findings of that phenomenon need to be brought out. In general, the findings resemble the findings related to disempowerment in other health contexts (see e.g. Lupton, 2013). As example, Nicolini (2007) found that in using digital mental health services, some of the patients felt overwhelmed and forced to confront their illness. As a consequence of that, these customers resisted or evaded from using the service or at least expressed that they would rather avoid using it. That kind of experiences are usually explained by technophobia, indifference or lack of competence and to be more general among older people (Oudshoorn, 2011). However, findings of Oudshoorn (2011) show that also young people experience similar effects. They engage rather in physical than in virtual contacts with the health care personnel. Also, in their integrative literature review, Newman, O'Reille and Kennedy (2015) concluded that the current models of mental health services lack the relation to real user involvement properties such decision-making and empowerment. Moreover, they found that many problems, such acknowledging problem, seeking help, continuity experience of the care and relationship building through service participation, were experienced in the services usage (Newman et al. 2015). However, in order to assess all these findings, it is remarkable to note that the research on digital mental health service acceptance has

merely focused on technological acceptance, not to the value creation perspective (Taiminen & Sarajärvi, 2018).

2.2.2 Facing stressful marketplace situations: Consumer coping and vulnerable consumers

In defining vulnerability in consumption, one often referred definition is offered by Baker, Gentry and Rittenburd (2005). According to them, consumer vulnerability is a condition, separating it from continuous status, that can be experienced by anyone, although some people are more prone to it. In the marketplace contexts, vulnerability appears in the consumption situations, that for example cause stress or negative emotions, like lack of social competence or unsafety (Falcetti, Ponchio and Botelho 2016). These situations may be experienced as risk of being stigmatized or as threat to the self-esteem of the customer (Adkins & Ozanne, 2005). According to Echeverri and Salomonson (2019), vulnerability can also be caused by experiences of lacking control or imbalance during market interactions. It can lead either to discomfort, commodification, referring to situations in which the consumer experiences to be treated with no feelings or own will, or to disorientation, referring to experience of being ignored or spatially confused (Echeverri & Salomonson, 2019).

To these situations, consumers respond by various coping strategies. They are different acts towards attempt to mitigate vulnerability, and balance it with the way the consumer wants to be perceived in relation to the service provider. (Echeverri & Salomonsson, 2019). Coping strategies are driven by the will to be independent and to be treated like other consumers. However, at the same time vulnerable consumers are dependent on the service provider. Thus, the emotional constraints may be experienced to be so high that coping strategies are needed in the situation. (See e.g. Echeverri & Salomonson, 2019). According to Baker et al. (2001) that is also the reason why consumers may express vulnerability and independence at the same time.

Situations, in which the vulnerability is experienced to exceed the ability to cope, consumers are found to withdraw from the social exposure to find safety (Adkins & Ozanne, 2005) or to avoid the market place situations in general (Duhachek, 2005). In the marketplace, avoidance can actualize for example as choosing easier payment methods (Falcetti et al. 2016) or as avoiding of shopping in physical environments, like stores (Elms & Tinson, 2012). On the contrary, if the level of vulnerability is experienced to be bearable, consumers are found to develop active coping strategies. That kind of behavior is found to be more likely in situations, in which the service is perceived to be empowering (Echeverri & Salomonson, 2019).

In theory, coping strategies and skills can be based on altering oneself, the consumption situation or social others, like relying on other people to go through consumption action (see e.g. Duhachek, 2005). Traditionally, the coping strategies are seen to effect on consumer behavior so that the consumers either become more vulnerable or resistant to their vulnerability (Antoniazzi, Dell'Aglio and Bandeira, 1998). However, more context-specific forms of coping have been recognized recently. For example, Duhachek (2005) argue that coping strategies can be recognized as attitudinal and behavioral strategies, that can be further classified based on two dimensions. As the first dimension, Duhachek (2005) recognize the way how consumer take actions towards vulnerability - whether they take active strategies to get through the consumption situation or whether they rather avoid or deny the stressors caused by them. The other dimension are the emotional responses of consumers, that vary between rational and positive thinking and expressing the emotional suffer (Duhachek, 2005).

Other example of vulnerability research is made by Adkins and Ozanne (2005), who analyze the consumer behavior in consumption situations involving stigma. In order to recognize the types of coping behavior, Adkins and Ozanne (2005) present a framework, in which the consumer actions can be defined by two dimensions. Firstly, actions can be defined by how consumers manage the stigma (on passive-active scale) and secondly, by the level in which their buying behavior becomes socially constrained. In their research, they recognize four types of responses: social isolates, whose coping skills are limited and as reaction they narrow their social interactions; social deceivers, that possess little more skills and respond acting little less unconstrained and identity exchangers and proficients, that both face the fear of social evaluation and reject the label of being stigmatized by actively participating their market behavior. This active participation can be deployed in different ways of acting, for example by asking help or by giving instructions to the service provider. According to Adkins and Ozanne (2005), those forms of coping in which consumer face the vulnerability are more likely to develop better coping skills. As a result of that, the consumer feels more confident and gains his/her self-esteem to act in the market place (Adkins & Ozanne, 2005).

Thus, the behavior of vulnerable consumers is dependent on both the experience and abilities of the customer and on the features of the specific consumption situation. Lastly, because this research is conducted in the context of digital services, a notion of the still rare research made in that field need to be mentioned. Namely, not like they forwarded, Elms and Tinson (2012) found out that, the online environment did not empower the consumers very effectively. Comparing consumption in digital and physical environments, they found out that although on one hand, online environment removed the impracticalities experienced in the physical environment, it also affected to feelings of normalcy

acquired through ability to shop. That again, led easily to experience of stigmatization and to isolation and exclusion. Their findings also support the view, that as the consumers were required to face the vulnerability in physical locations, they also developed their coping skills and gained the feeling of normalcy.

3 METHODOLOGY

This research is qualitative in nature and methodologically based on a constructionist view of understanding reality as a form of social constructions, that are continuously created and shared in specific contexts by individuals (Eriksson & Kovalainen, 2008). In the following sections, the methodological basis, the context of the study, data collection methods, and data analysis of this research are introduced.

3.1 Research methodology

This research relies on interpretative phenomenological analysis (IPA), in which the research focus is in constructing meanings of the lived experiences. IPA focuses on how people make sense of their experiences, for example the transitions in life, and how that sensemaking turns into decision-making. Characteristic of IPA research are small sample sizes and in-depth conversations, because the focus is on detailed, individual examination of the specific experience. It is used in research of diverse range of phenomenon that are based on some sort of social interaction (Smith, Flowers and Larkin, 2009).

From theoretical foundations, IPA is a qualitative research approach that relies on the assumptions of phenomenology, hermeneutics and idiography. The role of phenomenology and hermeneutics is essential in the epistemological assumptions of IPA. The research focus is on experience and its perception, and knowledge is sourced from people who deliver it by exploring their experience on their own terms. Thus, the knowledge is always tied to personal experience and perspective, but it is also liked with the experiencer's social contexts and realities. Also, the role of the researcher's interpretation is central in building understanding, because the access to the experience is limited to what the researcher is told. Based on that, the researcher is making sense of the appearance of single experiences and facilitating it to contexts. The hermeneutic underpinnings are emphasized especially in the analysis part of the data. When the researcher looks at a single experience of the individual, the see it as phenomenon which can be interpreted as a part of more general contexts. Lastly, the main theoretical underpinning from idiography is the emphasis of the importance of single case studies in examining of larger constructs in general level (Smith et al. 2009).

3.2 Context of the study: Internet therapies

This research is made in context of internet therapies provided nationwide by a well-known hospital in Finland. This research is not a commission from this hospital, but objectively and independently conducted by the researcher. However, the research is made in cooperation with the service provider so that consulting and the data, two interviews, were offered by the service provider during the research.

Internet therapies can be classified as a self-guided web-based therapeutic intervention (Barak et al. 2009). According to Barak et al. (2009), this service is self-guided and human-supported, formulated, modularized and a highly structured intervention that is designed to create positive, cognitive and emotional changes. The digital service examined on this research consists of nine different therapy programmes to treat insomnia, depression, generalized anxiety disorder, panic disorder, social phobia, obsessive-compulsive disorder, alcoholic abuse or bipolar disorder.

The service provider further portrays the service as being controlled, but self-responsibility based treatment, realized in an internet-based learning environment platform. In the therapy programs, the customer and the therapist attend the service separately from their own physical environment and at different time. The service consists of information-based contents materials, like texts, videos, photos or recordings and exercises. The material is built on evidence-based medicine and includes information about mental health disorders and the factors sustaining them. Although the communication between the customer and therapist is not simultaneous, the service includes a phone discussion with the therapist at the beginning of the program, and the during the program, the customer has a possibility to contact the therapist with message board quite similar to email. According to the service provider, the service is targeted for people with newly occurring or mild mental health problems. The service is free of charge for the customer and a referral to access the service can be received from a doctor.

3.3 Data collection methods

The data was collected by semi-structured phenomenological in-depth interviews. That choice was made because the interest of the research is in detailed descriptions of personal experience. Altogether nine interviews were carried out, seven from the potential customer and two from the service provider. The interviewees as potential customers were recruited through an announcement posted on the news of Tukinet.net, which is an online crisis centre provided by The Finnish Association for Mental Health.

Also, the announcement was posted in few newsletters of non-profit organisation and wellness media actors and in Facebook-groups in wellness and mental health contexts. The channels were chosen based on google-search to resemble the reality of what people might come up with if they seek for help. The researcher had no previous connections with these channels.

Interviewees. The sample of the potential customers consisted people, who had experienced exhaustion, dejection, anxiety or panic symptoms and had considered seeking help for these feelings. Having a diagnose for the problem was not a selection criterion, nor further discussed because the focus of the research was in conceptions of potentially being a customer of internet therapies. Thus, all the interviewees were people that had not used internet therapies or other forms of digital treatment services based on evidence-based medicine. Common for all the interviewees was that they experienced that their condition challenged their getting along with normal daily routines (e.g. work, school, taking care of children, housekeeping) and social interaction. All the interviewees expressed that they had tried to look for help for their current symptoms but that help had not been sufficient. Some of the interviewees had previously received help to some other disorders (like eating disorders) previously. However, people with severe acute mental health disorders and people with intense periods of specialized (psychiatric) health care were excluded from the sample. Because of the delicacy of the research topic and to protect the anonymity of all the interviewees, all of them are presented with pseudonyms.

All the interviewees were 23-35 old and represented different cities, all included in the ten biggest cities in Finland. Sample of more women (6) than men was targeted, because in Finland during 2010-2017, more than half the users of mental health services were women (Järvelin, Kääriäinen, Vainio and Passoja, 2018). The targeted customers were to represent "potential customers" of the internet therapies. The selection criteria were defined in conversation with the service provider. The size of the sample was pre-planned to be 5-10, because of the nature of phenomenological research (Smith et al. 2009). However, new interviews were conducted since the data reached its saturation point. The interviews from the service provider were given by two leading figures of the unit, in which internet therapies are managed and developed. As the research is conducted without bringing forth the name of the hospital, also the names of these representatives are replaced with pseudonyms.

Interviews. In the first step of the process, the interviews were loosely structured by three themes: being a customer in mental health services; perceptions of mental health services and internet therapies; and the relationship between the customer and the service provider. Themes were based on

the researcher's understanding of the most relevant theoretical issues emerging from the literature review. Few questions, like "What do you think is the role of customer / service provider in internet therapies?" and "How would you describe the typical customer of internet therapies?", were prepared to guide the flow of conversation. Still, the structure was left in between open and semi-structured interview to leave as much room as possible for conversation and detailed questions. These decisions were made to follow the research tradition in phenomenological interviews, in which the aim is to hear the interviewee as the only expert of her experience and to find questions to ask for words that what were left unsaid at first (Smith et al. 2009). All the interviews were audio-recorded and transcribed verbatim. Each interview was 60-90 minutes long.

Four of the interviews were carried out as face-to-face conversations and five of the interviews were done via Skype or as phone conversations. To ensure conversational and relaxed atmosphere, all the interviews started with demographic question and explanation of the purpose of the interview. First, the interviewees were asked to describe the pre-perceptions regarding the three themes. After that, the idea of internet therapies was loosely explained to settle the conversation into the right context. That choice was not pre-planned, but it quickly become apparent that in general, the interviewees were confused about the term internet therapies which might have affected the purpose of the interview. During the conversation, further details were given about the service if needed, for example in cases where the interviewees confused the service with social media conversation platforms. However, strict detailed descriptions of the service were avoided to keep the perceptions as authentic as possible. Also, the name of the service provider was not mentioned to exclude perceptions that the interviewees might have had about the service provider as an organization. All the findings discussed in chapter 4.2. are based on the perceptions after the explanation, if not otherwise mentioned.

During the interviews, the interviewees were asked to describe their experiences in their own way. If needed, the interviewer asked them to, for example, evaluate or compare their experience to something else, in order to find ways to verbalise the experiences through metaphors, narratives and by describing opposite phenomena. The interviewees were also asked to further portray and probe their experiences with descriptive questions like, "Can you portray what images come to your mind when you think of the target customer of internet therapies" or "Can you understand the outline of what makes you think so?", to gain understanding of the deeper constructs of their experiences. However, as the focus in in-depth interviews is listening of the interviewee, the involvement of the researcher was minimized and the interviewees were let to talk without interruptions (Belk, Fischer and Kozinets, 2012).

After the main issues had started to reoccur in the conversations, the interviewees were asked to further portray the themes discussed in the chapter 4.2.2. and 4.2.3. Free of form pieces of texts were requested to deepen the understanding of the nature of these findings and of their drivers. The interviewees were asked to take their time in considering the themes and in writing about the thoughts and feelings they provoked, and whether the interviewees could name reasons for their reactions. 6 out of 7 interviewees replied to the request, two of them however preferred to portray their thoughts as interviews.

3.4 Data analysis

The data analysis was mainly conducted in line with the suggestions of Smith et. al (2009) about making an analytic process in interpretational phenomenological research. The written texts were analysed by data-based content analysis. Different tools, such as open coding, lists and figures, hermeneutic circle and memos, suggested that qualitative analysis should be utilized (e.g. Belk et al. 2012).

At the beginning of the analysis process, the researcher made herself familiar with the data by reading the written texts and all of the transcripts of the interviews. After one round of only reading, the materials were re-read line-by-line and marked with initial notes, descriptive and contextual comments. At the second step, each interview and piece of text was marked with codes. All potential codes were picked up and listed as initial codes. Initial codes were marked by their repeating elements, patterns and similarities that the researcher found to portray similar categories. All central codes were then marked and clustered into emergent initial themes in order to see how the individual elements relate to each other. Initial themes were formed by building combinations of initial codes to portray wider constructs, such as general experimental claims or understandings.

In order to deepen the understanding of the data, memo writing technique was used. Memos were written both about the interviews as single stories and about the initial themes. Based on memos, the first version of main themes was drafted. After that, the draft of the main themes and the data material were in turn read line-by-line to find convergence and divergence between each interview and each theme. The idea of hermeneutic circle was used to help find relations of single and common experiences and the phenomena as larger structure. The themes were reduced and modified multiple times in order to minimize potential overlapping of themes and to make the core of the themes as clear as possible. As the main themes started to settle, they were connected to the interviews by

choosing quotes that best portrayed the theme. Finally, the main themes were formed, and the texts were further interpreted to create a synergy between the descriptive and the interpretative.

4 FINDINGS

Through the analysis, three bigger themes recurred from the data. Each theme is represented, in the following chapters 4.1, 4.2 and 4.3. In the parts 4.1 and 4.2, the findings concerning the background, determinants and the behavior of consumers are explained. In the section 4.3, these findings are more detailed discussed in the context of internet therapies. These themes express three different facets to explain the phenomena. They are, however, tied to the interpretation of the researcher and therefore they should not be considered to be ruled out of the as possibility of similar traits or overlaps with each other. All the themes considered in the findings are drawn from discussions after the informants had been explained the idea of internet therapies. In few cases, also the preconceptions are discussed. In these parts, the role of perceptions as preconceptions is mentioned.

4.1 Mental health consumption: category illigitimation

In all of the interviews it became apparent that the informants struggled to perceive consumption culture for mental health services to exist. Mental health services were not seen to be in accordance with accepted standard and rules of consuming. Consuming, as a phenomenon, was considered to include decision-making capabilities and feeling of agency. Furthermore, the idea of recognizable consumption culture around a consumer practice, was something that was linked to consuming. In mental health, the informants however did not recognize any of these features to exist. Instead, they found the idea of active consumerism in mental health irrational and utopian. Interestingly, in consuming of health in other practices, instead, these features were recognized to exist.

4.1.1 Insufficient Agency: Consumers as unfit for consumer role

As became apparent in many of the informants' narratives, consuming of health was linked to the logic of consumable practice but mental health was not. The contrast was found to be even bigger, if the informants compared consuming in mental health and in other, not health-related services. Also, it become apparent, that the phenomenon was subconscious and difficult to explain. However, three themes recurred in the narratives: lack of decision-making capacities, unavailable agency and nonexistence of consumer culture around mental health.

Lack of decision-making capacities. In the narratives, lack of decision-making capacities was explained by lack of realization and by decreased capability to process information. At the time the informants were getting ill, most of them had not experienced any risk in their health state. The idea of being in a need of help, was something that had not even come up to their minds. In many cases, the need for the service was recognized by someone else. Moreover, that has happened at the time, the informants think that their illness was already so bad that active participation to seek help had become impossible. The informants portray how they would never had considered themselves to develop an illness nor to be the one who whould be in a state in which seeking for help was needed. Afterwards, they think that they had had lack of knowledge considering the early symptoms of emerging mental health problem, as becomes apparent in this Annika's account:

> *Annika: Yeah, there's no way. So, I wrote on our wellbeing survey at work, that even though I mentioned that I'm about to have a burnout, despite the fact that I managed to write it down, I never could have believed that I would get ill, like eventually.*

In some of the narratives, the lack of realization was seen to stem from the problems to process information properly. Informants described how they think that, during the illness, they suffered from cognitive problems and the most of their behaviour was subconscious. The problems were also understood with delay. Not even then, the phenomenon was fully understood, as Nella portrays:

> *Nella: Because if you're mentally healthy, you don't care how much information you get. So, in the end, the person has the choice, if they have a full capacity to do things, but often a mental health patient, their mind is not like fully in use, so that conventional solutions and taking responsibility of the treatment is many times quite challenging. So, in a way if you were directed to a nutritional therapist, if you were completely functional and mentally healthy, you'd have to go there. Or to a dentist, so it's a complete waste of time that mental health service providers keep tabs on whether you've been there or not. But when your mind is broken, you need a little bit of support. Because at least I, even though I'm very pedant by nature, when I first got ill, I lost all focus and it got so bad that in the end I couldn't remember anything, I even left the stove on, so how can you really expect that that kind of a person makes a treatment plan for themselves, I think that's a complete impossibility.*

Like Nella and Annika explain, they had experienced problems to act independently to seek help or to recover alone. Like Annika portrays, she didn't recognize that she was getting ill. That is why she neither recognized any need for the service. These narratives are in line with the notion of Newman et al. (2015) who argue that in mental health services, there are many problems such acknowledging problem and seeking help. Moreover, both Nella and Annika seem to blame themselves, and partly the situation, for not realizing that they were getting ill. So, apparently, there are many conflicting emotions involved among health services users. These experiences thus fit to the literature, that notices vulnerability as one of the characteristics in health care consuming (e.g. Sintonen & Pekurinen, 2006 p. 44-51; Robert & Macdonalds, 2017 p. 117).

Lack of agency. Other recurring theme to explain the difficulty to consider mental health services as consumption practice, was the lack of consumer's agency. That was something that was perceived to normally belong to consumer. In the narratives, the agency in consumption was perceived as power over the service journey and as power over the target of the consumption. All these were perceived to lack from mental health services, but interestingly, to be in linkage to other forms of health services.

In general, the service was perceived as a concept in which the customer was in power to decide whether to consume or not. Also, customer was perceived to be in a position to give feedback and to hold some kind of a grant of the value of the service. As a concept, being a customer could not be associated to public mental health services. However, in private sector mental health services, the idea of being a customer was reached in few narratives. In general, that state of the powerful customer was explained to be reached through investment of money for the service, like becomes apparent in the explanation of Sanna's.

> *Sanna: Well, I feel like now that there are services in the private sector, such as Vastaamo, you're more of a customer when you use these private sector services. It used to be, I feel like before you were just a patient and you took what was given to you, because the state of mental health services or how easily they're available to you has not always been something to gloat about…I think these people do presume that when they pay more for their care in the private sector, they get a little bit more. Or that if they say 'I want these blood tests' then no one comes up to them and says that they don't need the blood tests and they should go away. Then you're being told that it might not be necessary, but we can take them, you're paying for all of this.*

The association between service and money is an interesting finding, that might show how the informants recognize the existence of the neoliberal health landscape that, for example, Fotopoulou & O'Riordan (2017) portray. The division between perceptions of private and public sector services, for example, might be explained by the emerge of new markets, as one dimension of the modernization (e.g. Dean, 2008; Kristenssen et al. 2016). In Sanna' s narrative it namely seems, that the act of consuming is easier to link to these emerged new services, that are many times provided by the private sector. The problem to identify customership in public mental health services become apparent also in Juulia' s, Jasmina' s and Sanna' s narratives. For example, Juulia explains, how to talk about a customer sounded more human than to talk about a patient. She further argued, that she associates a service provider who calls her customer to be willing to give a good service experience to her. Furthermore, Jasmina portrays how she thinks that in mental health customers can be linked more to the private sector, because people commit to the service by themselves. In public health, she also mentions, that the service provider makes the decision whether the customer can consume or not, in spite of the customer's opinion. All this portrays, how the discourse of health has changed and the term patient has been replaced with the term customer in many cases (Ayo, 2012). However, it seems that mental health is perceived to be problematic to fit in to this discourse. That become apparent, when the informants were asked to describe, how they would portray a mental health service as form of consumption, features like having daily contacts and someone to track their mental health state were mentioned. However, they also noted, that they didn't know any services like that to exist. For example, Jasmina and Sanna both compared the service to care services of older people.

> *Jasmina: I think it could be compared to when our grandpa was in a nursing home, when you pay, a nurse will visit him every morning and a doctor will visit him twice a week. So, if you pay, you will be served… So I think if you pay big money for internet therapy, they probably keep tabs on how you're doing?*

Another issue that recurred in the narratives of informants, was the involvement of emotions that were not perceived to appear in other forms of consuming. These emotions were explained as lacking willingness to consume and as fears of not being accepted as a consumer. For example, Osku, Jasmina and Nella portrayed how they feared, that their symptoms would be dismissed, and how they feared of being not met up as a person. Iiris, then again mentioned that she had felt ambivalent towards the idea of help, because she had in some level fell in love with her illness. Also, the fear of being a to to other people and the fear of failing to attend to the service were mentioned. For example, Jasmina, Iiris and Nella brought out that they feared that the mental health personnel was already too

oversubscribed. Again, notable however was, that these feelings were perceived to appear only in mental health services. In other forms of health service, most of the informants brought out, how they perceive the norms of consuming almost contradictory. The phenomenon is portrayed in this narrative of Jasmina 's:

> *Jasmina: I don't want to be a burden to anyone and then I sometimes wonder if I'm making things up and that maybe everything is fine and I do just like drama, do I like to live surrounded by drama, is that all it is, because everything is fine... like nowadays you have all kinds of fat camps online and exercises and stuff, so people do pay a lot of money for them. But just as I'm thinking of this, I also realise that I can't invest money in it. I would lose this and this much money, but like even at the moment, if I had to see a psychotherapist once a week, which costs 85 euros, the psychiatrist would have to be really fucking good…Even the (diagnoses) are so incomprehensible and there are so many different forms of therapy that you can find out about them if you just go online to read. But like after that I feel like shooting my brains out, because there are loads of search results for anxiety and depression.*

In her narrative, Jasmina describes how she experiences accessing to mental health service to be ambivalent. In her narrative, she portrays reactions of avoidance to search information, that e.g. Berry & Bendapudi (2007) portray to be typical in health services. In the narrative of Sanna' s it seems to origin from perceiving the service as something hidden, complex and understandable only by professionals. Both Sanna and Jasmiina portray, how they lack proper abilities and motivation to take control of their health. These both are found to be key components in consumer empowerment (e.g. Fumagalli et al. 2015). Thus, as phenomenon it seems, that these informants experience lack of competence with their disease. For example, Prigge et al. (2015) explain that the lack of competence can come out as need for find information and develop the knowledge. The lack of both of these characteristics is clearly recognizable in the narratives of Jasmina' s and Sanna' s. In general, this would be also in line with the notion of, for example Newman et al. 2015, who argue that the current models of mental health services lack relation to user involvement properties such decision-making.

Nonexistence of consumer culture around mental health. In all the narratives, it become apparent that the informants had problems to recognize consumption culture around mental health. Consumption culture was something that was recognized in other services, including other health services. In the area of the other health services, the active and empowered consumer was recognized to exist. However, consumption in mental health services wasn't seen to be similarly acceptable. This

was reasoned to arise from the, societally shared, ideas and norms, according to which, it is neither suitable to have mental health problems nor to ask effort from other people to help with them.

One of the explanations for this phenomenon was mentioned in the narrative of Nella. She portrays how she things that people usually talk about depression calling it as "some problems with how you' re getting on", although that person would be clearly depressed. The culture of talking aloud of mental health was seen to lack and as something secret and even mysterious, like Jasmina portrays.

> *Jasmina: I think that people don't have the knowledge and everything strange and unknown is perceived as a threat and as being wrong. Like only now it is legal for gay and lesbian couples to get married in Finland, still, you can see people staring at them… I think it should be discussed more, we should have mental health education, because we have physical education, why couldn't we also have psychology. People take care of their cars, they get insurances for everything, but they don't take care of their mind.*

Similar cultural features were recognized in the discourse about people with mental illnesses or with a possibility to have them. In all but one of the narratives, it become apparent that it was perceived as a rational choice not to tell anyone about mental health problems, if having one. That was explained to include a risk to affect to economic ja societal possibilities like having a job. In her narrative, Jasmina explained this by arguing: *"Knowledge is power, please say as little about yourself as possible, so no one can hurt you".* Also, Annika mentioned, that she has that kind of impression that being deeply depression would equal to *"something is wrong with you".* These opinions, perceived to be shared by *"other people",* were seen to be unideal. At the same time, however, they were seen to be something beyond their control to change, like becomes apparent in this Annika's account.

> *Annika: So up until a certain point it kind of fits, but then, for example, in the work life where you have to be always more efficient, where no stress management skills are required. So yeah, the means you need for taking care of yourself. Yeah, I've had to learn stress management skills and making schedules and I also like go to yoga and I do mindfulness and what have you, and I try to maintain a regular sleeping pattern and see friends and I try to live as balanced a life as I can. But still, despite that, the demands of work life and the pressure, it just gets harder and it's really hard to take responsibility for the vastness of it all. So not everyone can endure stress as much, so society should take care of the weak.*

Lastly, in this discourse by other people, people with mental health problems were seen as weak and unsuccessful. There seemed to be experienced cultural restrictions to consume mental health - or at least, it was seen as something not desirable. For example, Jasmina portrays, she thinks mental health to be stigmatized topic, including many risks for social status. People in a need of mental health service consumption were seen in negative light, too weak to be as other citizens, as Sanna explains:

> *Sanna: Well, it easily feels like there's something wrong with me and that I'm too weak, and that I should make it on my own, and especially in Finland you should just make it on your own and not need the help of others. So you might have thoughts like 'maybe I'm not ill enough' and 'am I taking the place of someone else?' And like 'maybe I should hold on for just a little while longer, what will people think and what will I say at work if I have to go to therapy in the middle of the day?*

Like becomes apparent in the narratives, having a need for mental health service is seen as risk. That is in line with how, for example, Corrigan (2004) portrays, that the stigma still exists around mental health culture. Moreover, the narrative of Sanna' s portrays findings similar to the findings of Adkins & Ozanne (2005), who explain that the experience of being stigmatized or as threat to self-esteem could lead to vulnerability experience, and thus, to the use of coping strategies. Also, these emotions are similar to what Falcetti et al. (2016) portray as a source of vulnerability experience in the market place: stress, negative emotions and lack of social competence. In general, from the types of consumer responses, that Adkins & Ozanne (2005) mention to appear in the market situations involving stigma, the narratives of this study portray the types of social isolates or deceiver. Like Sanna portrays, her thoughts had led to lack of reaction, which over time, had led to the lowered state of performance. That is in line with how Adkins & Ozanne (2005) explain that social isolates and deceivers can behave: narrowing their social interactions and expressing passive management of stigma.

4.1.2 Lack of clarity of consumer subjectivity

Other theme that reoccurred in the narratives, was the lack of consumer subjectivity in mental health. In the narratives, the consumer subjectivity in mental health seemed to be something, that could be barely imagined but was almost impossible to portray. As a concept, it was portrayed by norms and terms borrowed from the discourse of customership in other health service. Notable, however is, that although the consumer subjectivity in mental health could be partly imagined, it was not experienced to exist, at least for the informants. It seemed, that the crucial difference between the consumer subjectivity in mental health and in other health services was, that the informants did not know how

to represent themselves as customers. Actually, it seemed that the consumer subjectivity was like a flawed concept, that lacked discursive constructions and norms to be realized as concrete representations of customership.

Instead, in other health services, the consumer subjectivity was perceived as a clear concept. When discussing the customer of health services, the informants seemed to have a clear vision of what kind of a role to fill. It seemed, that there were clear rules and norms for the customer of health services. Throughout the narratives, the clear consumer subjectivity seemed to be the foundation for active participation in services. Also, important for the informants seemed to be, that they could recognize and define the concept, and that they could find themselves to be part of it. However, throughout the narratives, reoccurred a recognition, that the consumer subjectivity was not found similarly in mental health services. That phenomenon was found to be irrational, because at the same time, mental health and other forms of health were both perceived as concepts of health. The conflict in between these two consumer subjectivities is apparent in the narrative of Nella's:

> *Nella: On the other hand, we have this clear polarization. Nowadays there's some unnecessary medicalization, we go to the doctor' s to have our lungs checked out, even though we just have a little flu, and we don't take care of ourselves at all. And then, for example, in rehabilitation, the responsibility of the customer is that the rehabilitation happens with all of the exercises at home and all that, or with nutrition, lifestyle changes. It's good that the responsibility is transferred to the customer, because the customer makes the final decisions.*

Like becomes apparent in this narrative of Nella's, the active consumer was recognizable and acceptable in health services. Like Nella portrays, being active in health services seems to be not only acceptable but also suggestable and even responsibility of societally responsible citizens. That shows, how the modern health care customers are loaded with assumptions of being responsible and active (Crawford, 2006) and to react towards provided guidance of healthy living (Ayo, 2002). In general, the narrative of Nella' s portrays, how the modernization of health care consumer is recognized (e.g. Askergaard & Schneider-Kamp, 2019; Kristensen et al. 2016; Ayo, 2002).

The reasoning behind the lack of consumer subjectivity in mental health appeared to be difficult to explain. Throughout the narratives, it was portrayed by comparing it as something opposite to the consumer subjectivity in physical health. However, two ways to explain the phenomenon were used

in the narratives. Firstly, in four of the narratives it was noted, that physical disorders were visible and needed not to be explained to other people. This becomes apparent in this Annika's account:

> *Annika: Because you can't really see it, like if you have a broken arm, like each person you meet can see that you have a broken arm and they immediately know. And next time when you meet the person, the broken arm is still there kind of as a reminder, but let's say, if you have to see your friends because your doctor ordered it, and you have to do fun stuff that helps your recovery and you've seen your friends and you've told them about your illness, it might be that after an hour, your friend forgets that you have burnout symptoms and you can't take part in activities like was planned, because it's not visible in the same way. So, it might limit some people, they might feel that they're not taken seriously.*

Other explanation recognized, was the unwillingness to take responsibility of the situation, in which the mental health problems were recognized. Irrationally, in some level, the responsibility was wanted to be kept by oneself and it was not perceived acceptable to pass to the duty of the nearest. However, in some level, it seemed that taking care of the problems was seen as society's responsibility. Half of the interviewees recognized that the responsibility needs to be taken by oneself. However, when talking about who should take responsibility, for example in a case, in which the customer stops using the therapy service, controversial thoughts appeared. In many narratives, the informants mentioned that they would think it as a service provider's task to react. Service provider was expected to, for example, help out finding more help to customer, or at least to ask the customer, why she /he did not attend the service anymore. That was also perceived as one of the reasons, why the informants found that mental health services are different from other services. This becomes apparent in this narrative of Sanna's, in which she compares hairdressing and mental health services.

> *Sanna: It's this long lasting and comprehensive treatment that in a way. It doesn't matter if your hair is a bit messy, but if you quit a long term therapy relationship, there usually is a reason, and it should be noticed. I do think these (mental health services) are kind of care services and especially for those people whose symptoms get worse, you easily cut out people from your life and you don't go to therapy. So really the only one who knows about it is your therapist, so they do have a moral and a societal responsibility to take care of it, and I think it is part of the treatment to say 'hey, you haven't attended your therapy sessions in a while, can you name any reasons why? have you been ill, or?*

In these narratives of Annika's and Sanna's two phenomena emerge. Like Annika explains, she would find it easier to explain a broken arm as a reason for a sick leave. It seems, that for Annika, physical reasons were seen as more important and legitimate to be taken care of than the mental health reasons were. This fits to the findings of Cavusoglu & Demir-Kaplan (2017), who found out that people expressed the most discussion about health in topics that concerned physical forms of body. Throughout the narratives, it seemed that the consumer subjectivity in mental health was experienced to be reactive as its nature, while the consumer subjectivity in other forms of health was experienced to be more proactive. In general, the difference seems to origin from the different nature of these concepts and from the lacking discourse of mental health customership. That becomes apparent also in the narrative of Sanna' s, in which she explains how she doesn't know how to explain her mental health situation. As phenomenon it seems, that there is lack of customer subjectivity in mental health and clearly the consumers lack of understanding of how to act.

4.2 When evaluating the service quality, digitalization is not the main concern

The digital environment was not perceived as problem as itself when deciding whether to consume the service or not. Perceptions towards digital solutions in mental health services were, in contrary, perceived as a positive development. For example, they were seen to offer a way to new treatment options. Most of the informants mentioned that possibility to attend therapy from home sounded easy and would probably lower the level to start using the service. Jasmina and Sanna further argued, that internet therapies would probably offer a way to avoid awkward waiting rooms and to safe time in transitions between physical locations. Going to digital therapies was also seen easier to keep as a secret. Iiris and Juulia further brought out that to them internet therapies didn't sound as much stigmatized, because using internet symbolizes something modern and that internet therapies did not sound as serious as meeting a psychologist would sound. When asked whether the interviewees would rather tell their employer that they need to leave work for internet therapy or for a physical therapy meeting, three of the informants thought that they would prefer the first option (and the rest saw no difference). In this regard, the findings are in line with findings of, for example Ostrom et al. (2015) and Ekeland & Bowes (2010), who argue that the digitalized systems could be seen as one solution to face the problems of current health care services.

Instead, it became apparent that there were two, emotion-based reasons guiding the perceptions towards mental health services: the level of human attendance and the feeling of responsibility. These factors become apparent during the conversations and were not hypothesized by the researcher. That is why, as the importance of the themes emerged, the interviewees were asked to further portray their

perceptions in the written narratives. In order to understand the reasons for the perceptions, the discussions and narratives were built on comparing differences between three service options: physical (face-to-face) service, service with video and / or voice connections and to self-guided web-based services based on independent working with tools such self-help material and writing assignments. The last option is an example to portray internet therapies, in which the patient and the worker work separately and communicate once by phone and otherwise on written conversation board.

4.2.1 Lack of clarity over service engagement

Physical (face-to-face) service. When comparing the three service options, physical meetings were perceived to be the most helpful and efficient. Five of the informants would prefer physical meetings as their first service option. These opinions based on three perspectives. Firstly, physical meetings were seen important in emotional level. For example, Nella portrayed that the attendance of other person gave her a feeling that she was important and that she could manage the stressful meeting and her situation. Also, Sanna and Annika mentioned that they would see it emotionally less stressful to attend the service without possibility of technological fails.

Secondly, three of the informants brought out the importance of the physical environment in order to get into "right mood". The environment was seen to represent an idea that the service time was limited only for them. For example, Sanna noted that at home it might be difficult to limit the service time for her own time because she could not easily stay undisturbed by children. Also, Iiris mentioned, that attending therapy session at home would probably feel like letting a stranger to her home. She further told that skipping out online sessions would feel easy because she doesn't want to bring difficult feelings to home environment more than was necessary. The two first perspectives are portrayed in this account of Annika:

> *Annika: Like, if you're sitting on a sofa and there's another human being and you get on well with them, the kind of genuine compassion is more easily felt, compared to having a computer screen in between you. Or in a video, the picture might crop out the therapist's hand movements so you'll only see their face. The kind of warmth that the therapist might have won't get through to you.*

Thirdly, in physical meetings, the communication was seen to be more human. In general, facial expressions and tones of voice perceived to be incomplete in digital communication. In physical

meetings, the level of human attendance was seen easier to reach, because more senses could be used in communication, like becomes apparent in this narrative of Nella's.

> *Nella: Well, a part of it has to do with our cognitive functions, instead of just thinking things inside your head, you kind of express them through different senses and it's as if you realize different things. Like when you say stuff out loud, and then someone asks you why you think that and then you go "oh yeah, you mean that". So, I think that digitalization is an opportunity which can be utilized better in the future and it's a good thing. In that kind of social work, it takes a certain relationship between people, and I don't think you can create that online by sitting home alone, it has to do with chemistry between two people.*

Nella and Annika both portray, how they prefer physical meetings. Thus, their perceptions can be supported by Oudshoorn (2011), who found that some consumers are still more willing to engage in physical than in virtual contacts in health care services. Moreover, the informants of this research brought out that one key feature of a good mental health service would be at least one personal meeting during the therapy treatment period. Like Nella and Annika both explain, physical meetings are perceived to offer characteristics that make the communication easier for the customer. For example, Nella portrays, how the ability to express emotions with all possible senses makes her perceive the communication to be more complete. Similarly, Annika explains, how in physical service, she does not need to guess the physical communication of the therapist's, because she can see it.

Service with video or voice connection. However, notable is that all of the informants saw physical meetings online and offline as almost equally good services. All the informants expressed that the ability to see each other either online or offline was necessary, because not all the difficult emotions or topics were possible to express only with words. The informants thought, that in face-to-face meetings (either online or offline) the service provider could also notice the feelings from customer's face. That was seen to be important for example in situations, in which the customer feels answering the question difficult but have no courage not tell it to the therapist aloud. In effect, all but one of the informants were interested in to try online service with video connection, to see whether their perceptions would meet the reality. For example, Juulia brought out, that although she respects traditional values and that she things that the core point of mental health service was the ability to deliver feelings, she suggests that face-to-face contacts could be carried out through digital connection without remarkable difference in the service experience. Similar opinions were shared by Jasmina and Osku, who concluded that he would need the attendance of a person, but the attendance

needed not to be physical. These findings are in line with the findings of Simpson & Reid (2014). Namely, they found that in videoconferencing psychotherapy, the communication through video was not perceived to decrease the effectiveness of the treatment or to lower the quality of the relationship with the therapist.

As more negative the services were seen when discussing a service without at least video connection. For example, Iiris opposed the possibility to communicate only by voice, because she suspected that without at least video connection her thoughts would start to roam, and she would easily start doing supplementary activities. Also, Annika mentioned, that the experience of being met was crucial in making consumption decision. That experience, she perceived to be possible to reach only by meeting (seeing) another person. She further explained that experiencing the bond with the service provider was the key factor in the service, through which she could built the trust that was needed in order to recover. Without the trust she suggested that the building of specialist-client relationship would be impossible. However, some of the respondents also thought that the minimum level of dialogical connection and mutuality might be possible to deliver via phone. However, through at least one phone conversation was needed to hit the minimum level. Although the quality of, for example, the phone service was seen worse compared to physical service, only three of the informants opposed the idea.

Self-guided web-based service. The quality of mental health service was seen significantly decrease if the elements of video and voice connection were deleted. When comparing the three service forms, the last option provoked conversation the most. None of the respondents would choose self-guided nor chat-based service as the only solution to treat their mental health situation. For example, Iiris argued, that she would be disappointed if she would be offered only with that kind of treatment option, because she things that the core thing in mental health service is to "process things with another safe *person"* (cursory was used by the interviewee). The efficiency and the quality of that kind of service option was seen to be low and in general, the informants were suspicious about the idea, like becomes apparent in this narrative of Nella's.

> *Nella: The kind of feeling of illness is weakened as well as your own view, so I'm a bit skeptic about who will seek that kind of treatment or how it is received. First, I think about men whose work is physically challenging and then I imagine them trying to answer questions where they really have to ponder the options, like with a straight question about imagining themselves in a certain situation, and I don't think they'd do that, it comes much more naturally when there's*

reciprocity. Of course, there are people who are a bit, who like to improve themselves and they might enjoy these types of tasks, but I think it' s kind of a shortcut.

To break down the reasoning behind the negative perceptions towards writing-based service, three perspectives were brought out: possible delays in communication, risk of miscommunication and increase in the negative emotions. Firstly, the possibility of delays in communication was argued to feel difficult and the waiting for services provider's reply was seen to cause negative emotions towards the service. This viewpoint is argued in this account of Annika, in which she explains why she finds writing to be inefficient.

Annika: I would evaluate it to be less efficient, because, of course I would understand it if the time was limited, like if there was a certain period of time during which you will get your answer, but like, when you have the symptoms the wait is really long. The amount of time you have to wait, when you're exhausted, I feel that it exhausts you even more. It's a bit different than seeking help for a regular customer service-related problem, you're feeling normal, but when you are burnt out, a simple thing like turning on your computer and typing your password, even that takes a huge amount of energy.

The risks for miscommunication, then again, was explained by arguing that writing about mental health issues would be challenging because the first reactions could be hidden, delivered and interpreted unlike the actor has meant. Annika further mentioned, that she assumes that she would easily avoid telling about her true feelings by writing because her situation provoked shame. Moreover, three of the informants pointed out that in a writing-based service, the customer would need exceptionally good skills to self-reflection. The problem of miscommunication was in general seen high, like becomes apparent in this Sanna' s account.

Sanna: If I had to do exercises that a nurse checks later on, I'd feel a lot of pressure about answering correctly and how they're going to interpret my answers. At worst, I would dwell on my answers long after answering. I wouldn't be able to specify any of my answers within a reasonable amount of time, if the nurse were to ask me what I meant when I wrote this or that. In that way, service isn't too flexible. With this kind of service, I'd feel like I'm not being met properly, and the treatment is worse. If, as an option, I was offered only this service (the internet therapy described) or medication, even though other options exist as well, I would pretty soon start to think why I'm not offered better treatment and have I not deserved it. It would weaken my motivation even more and make me more depressed.

Thirdly, the writing-based service was experienced to increase the possibility for negative feelings of the informants. Many of the informants mentioned that, especially, if they were tired the negative emotions would probably take over their mind in therapy working. In her narrative, Nella explains how her distorted ways of thinking affect her thoughts. That is why she feels that therapy working alone would cause her anxiety. This becomes apparent in her account in which she portrays how she would need the service provider to work as a quality assurer to help her build more healthy ways of thinking.

> *Nella: These thoughts are like a partner, who's at your ear, constantly complaining that you are shit, how you could you not do even a simple thing like that, why didn't you do this, everyone hates you. I would think that when you have a distorted brain like this, when you're reading the nurse's reply, you might easily slip and interpret it so that the nurse isn't interested or they're being rude, or whatever your brain comes up with at that moment. Your brain eagerly looks for signs that strengthen your own distorted self-image because it's something familiar."*

The narratives of Annika's, Nella's and Sanna' s can be seen to portray the different facets of vulnerability experiences in the service. Like both portray, delays and risks in the communication would cause them negative feelings, such exhaustion and frustration. Also, in her narrative, Sanna mentions that she equals writing-based service to low quality service. She further portrays, how the idea of being offered to use only that kind of a service would cause her negative feelings, such sadness and inferiority. In the light of the literature, it seems that both these experiences are caused by the imbalance found in marketplace situations (Echeverri & Salomonsson, 2019). Also, both offer a good description of how the digital service might be perceived as disempowering (Lupton 2013). Moreover, the narratives portray experiences that are found to be typical for vulnerable consumers (see e.g. Duhachek, 2005; Adkins & Ozanne, 2005). For example, Sanna' s experiences might be interpreted as discomfort and disorientation, being ignored and treated without feelings (Echeverri & Salomonson, 2019). Thus, the findings of this research support the default of this research, that mental health consumers can be considered as vulnerable consumers.

Lastly, again these problems were seen to be present only in mental health services and did not impact to their perceptions toward services in general. This supports the idea that vulnerability is context specific phenomenon (Falcetti et al, 2016). In services for standard or single one-off processes, like for banking services or travelling services, writing separately from the personnel was seen positively.

This can be seen in this account of Nella, in which she compares taking care of her mortgage loan and her mental health issues.

> *Nella: It was really quick and efficient to take care of things via e-mail and not go to the physical location, when you're mostly dealing with numbers. The difference between mental health treatment and speaking with a bank worker is that you don't speak about why you need love, but about your income and insurances. So at least according to my view, you share much less personal information like what's going on in my head and how I feel. And more facts than anything else. That's the difference, I think.*

To draw up the findings of this chapter, the level of human attendance was seen to decrease when the level of digital features was perceived higher. At the same time, the quality of the service was perceived to lower, like becomes apparent in this text of Sanna's.

> *Sanna: Physical presence, I think that makes the treatment more easily approachable and gives the patient an impression that they matter and that they're being met properly. The further you go from being physically present, from a meeting to video, from a video to sound, from a sound to chat, and eventually to messages sent via email, the more impersonal the experience becomes and I think that also impacts the patient's view towards the treatment and how positively they feel about it. I've once contacted a crisis chat online and the answer was, instead of a short but empathetic meeting, a short and impersonal message saying 'it seems like you need professional help, please contact this number'. Personally, I feel that text-based services are second to personal meetings, because I feel that in text-based services, meeting the other person is shallow. In chat, you can't see if the patient bursts into tears even though they're saying that they're fine. It can be pretty easy to avoid difficult subjects that you should still talk about.*

4.2.2 Unclear Consumer autonomy in service engagement

Another factor that effected to the perceptions of the informants found out to be the experience of the responsibility to co-create the service outcome. In this chapter, I discuss this topic from three aspects: how the informants perceived the responsibility, how it appeared through roles and resources and what kind of feelings it provoked among the informants.

Defining the experience of responsibility. Firstly, responsibility was perceived to equal to the level of autonomy and to the amount of individual work in the service. The experience of responsibility

was seen as a complex phenomenon, that needs more research to be better understood. In one level, the informants expressed to realize that the responsibility should be taken by the customer. They shared opinions that everyone wants to take the responsibility and that the patient needs to take the responsibility in order to recover. In this regard, the findings of this study are in line with the literature that portrays how the services are turned into co-creation (e.g. Sangjorgi et al. 2017) and how that has influenced to the traditional roles of health care actors (Askegaard & Schneider-Kamp, 2019). Also, the findings of this research support the findings that show, that the role of the customer has become more active (e.g. Black & Gallan, 2015).

These perceptions seemed to be based on understanding, that no form of care itself could recover the patient. On the other level, however, the informants expressed, that they felt that they were unable to take the responsibility and that it was too much required from the customer. The complexity to perceive the responsibility becomes apparent in this account of Nella.

> *Nella: Well, I would keep it to myself, but then again… the kind of weakened judgment and being unable to see your own situation are related to depression, so you might not realise where you're at and then it would be really important that you get the perspective of another person. A person might think 'oh yeah, I'll work this out with someone', but how it actually goes is different. It has to do with the culture of handling it on your own… The responsibility of the customer is really big and then, you feel bad and you wonder whether you're entitled to this treatment, which is the thought that a lot of depressed people have, the thought that there are people who have it worse, and your own sense of self-worth is low and your initiative weakens. So, it's totally ridiculous, someone should hold our hand and look after you, but that's not how it goes, you're responsible for getting things done. So, if you think about the symptoms of depression, it makes absolutely no sense that a person has so much responsibility of the treatment.*

Also, perceptions towards responsibility seemed to vary when the interviewees talked about the phenomena in general, as a responsibility of someone, and when they thought it from their own or their nearest' s perspective. When the discussion turned into their nearest or to themselves, responsibility provoked difficult and ambivalent feelings. The informants portrayed how the idea of taking responsibility of the treatment, especially at the beginning of the illness, provoked feelings like fright, guilty, powerlessness and incapability to get through the things that they believed taking the responsibility would require. That became apparent as denial and resistance towards the idea of

responsibility and as difficulty to name concrete acts to explain how the responsibility could be taken by the customer. In the following account, Annika portrays this phenomenon.

> *Annika: If I'm really burnt out and someone talks to me about taking responsibility and that I should get well, my brain just won't work. I don't feel anything, it's neutral, I don't understand the phrase, it's just absurd in that situation, to put me in charge. So my thought turn to 'where can I get help', so let's say I were more depressed and cynical, it would make me completely hopeless and the feeling of not being heard would just strengthen then, so the symptoms would get worse. When you need to get help, you really need to get it from somewhere, whether it's from the public or the private sector or even from your pet dog.*

In order to interpret the narratives of Nella' s and Annika' s towards the literature, they both show that the digitalization doesn't necessarily empower all customers (e.g. Lupton, 2013). Instead, they portray many of the findings that are made in the research focusing on vulnerability in consumption. For example, the narrative of Nella's is a good description of how the vulnerability and independence may appear at the market place at the same time (Baker et al 2001). Also, the narrative of Annika's show how the experience of vulnerability can lead to freezing (Duhachek, 2005) and how vulnerable consumers might be prone to find safety in the first place (Adkins & Ozanne, 2005). These narratives clearly show that vulnerability is experienced in the marketplace for mental health services. Thus, it might be assumed that, in that market, also coping strategies appear.

Responsibility as roles and resources. When discussing the roles and resources of the core participants of the mental health service, the customer and the health care professional, the perceptions varied between the informants. Especially, the division of the roles and resources between these actors provoked diverse opinions. Now, these roles and resources are further explained. In this discussion, they can be considered as roles and resources, in general in all mental health services, without further limitation to a specific format.

All the informants shared an idea that the role of the therapist was to listen and to find solutions to the customer. For example, Nella portrayed that the role included mutuality, guidance, asking questions and challenging of the patient's thinking. Annika also added that the task of the health care personnel was to deliver support and experience of being heard, that she called *"acceptive presence"*. Another type of tasks, that was mentioned, was the help with concrete issues such evaluating the situation of the patient and guiding the patient in the servicesscape. Also giving tips to read and study were mentioned in few of the narratives. As widest perception, for example, Osku brought out that

the customer should be met as a whole and that also, for example, his social service issues should be integrated to the treatment.

On the contrary, the role of the customer seemed to be more challenging to define and the perceptions of the informants varied remarkably. For example, Osku limited the role of the customer to include only the responsibility to attend the meetings on time. The general first stance in the narratives was that, outside the meetings, the patient had no responsibilities. However, most of the informants detailed later in the discussions that customer's task was to follow the guidance received from the service provider. As opposite perspective, for example Jasmina saw that all that comes to the mental health service seemed to be the responsibility of the customer. These perceptions however were connected to the time during the service and all the informants also shared an idea that after achieving enough information the responsibility of what to do with one's life was up the patient. However, the responsibility of the customer was clearly considered to be something unclear to be defined.

In general, all the informants expressed that they believed that the customer could not recover alone and another person, like psychology, therapist or someone with similar experience was needed to guide the customer. That is supported by Gammon et al. (2014) who argue that especially in mental health consumers long for assistance and guidance. As that kind of guide and as source of knowledge all but one of the respondents perceived the health care personnel to be the best authority. In the one exception, the informant (Osku) had experienced that conversations, for example in Facebook, with the other laymen, included information about the aspects of life than the doctors had not informed him, like nutrition, social relationships and sleeping habits. The role of other laymen as source of knowledge was also brought out in three other interviews. However, also negative experiences were shared, like experiences of competitiveness and comparing of symptoms among these people. In any case, these findings support the notion of e.g. Kristenssen et al. (2016) and Fox & Ward (2006) who argue that the role of lay-man as source of help has become more important.

The feelings that the responsibility provoked. Feeling of too much responsibility was linked to too much working on own time. It seemed that the fear towards too much responsibility did origin from uncertainty to know how much responsibility to expect and what it would mean as concrete tasks. The informants expressed how they would probably experience that they have been left too alone to take care of the treatment. In the most negative scenarios, informant expressed despair, guiltiness, inadequateness and fear of failure. For example, Jasmina explained that she feared that would not manage to do the tasks asked from her and that the pressure she felt would lead to avoiding the service.

The fear was limited, not only to doing the assignments, but also to the fear of physical symptoms that she feared the assignment would cause her. She explained that the exhaustion and anxiety she gets from her panic attacks would also lead to problems to get through next days. Also, Iiris explained, how the feeling of too much requirements would probably cause her feelings of guilty and uncertainty and she would experience it as a situation in which she questions herself why she can't recover. After analysing the narratives of all the informants, a logical finding was that these negative emotions led behaviour such as avoidance and hiding, like becomes apparent in this narrative of Annika's.

> *Annika: But let's say that for this situation, those exercises that you need to return and if they also had a deadline for when you need to return them. I feel like it might be one of the factors that add stress and anxiety, and, after all, you might not return them. If I think about going to the doctor at work and getting a diagnosis, it feels much easier that you can get a referral to a psychologist, and I won't have to do anything else than appear behind their door and the psychologist will take the lead in the conversation, and all that. Nothing is clear cut, when I was at the doctor's, we talked about whether I have depression or not, but like, there are some problems when you interpret things, like with symptoms, like how often do they occur, and here it's really up to the person to decide how often is often, so for those kind of things you'd be able to ask for clarification immediately.*

Like Annika explains, the experience of too much responsibility might lead to increase of anxiety and to end up to avoiding behaviour. The narrative of Annika' s resembles the behaviour, that is portrayed to be typical to vulnerable consumers. As a reason, she portrays, how she perceives the information regarding the treatment and her disorder to be complex and unfamiliar to her. The experience of Annika's can be seen to shows that the level of competence to take active role to treat their health state is experienced to be low among mental health customers. Moreover, this narrative shows, how consumers in the digital mental health services might experience similar feelings that the emerging literature has found to be present in the digital health care services in general: burden of invisible work and self-care (e.g. Lupton, 2013) and the feeling of being overwhelmed and forced to confront their illness (Nicolini, 2007).

Lastly, positive associations towards the responsibility and assignments were also recognized. However, all the positive associations were linked to back-end of the service. Also, the possibility to get help from the service provider and the certainty of not being left alone to accomplish the assignment clearly smoothened the attitudes towards the responsibility. When the level of attendance

of personnel rose, the perceptions turned in to be more positive. This could be explained by the finding of Gammon et al. (2014) who argue that assistance and proactive encouragement is needed among mental health customers. For example, the assignments were perceived as positive issue, if they could be gone over step by step discussing with the service provider. If the level of the assignments was perceived as agreeable, all but one of the respondents noted that the assignments would probably make the learning process (to recover) more effective.

To conclude, responsibility in mental health service is perceived to be the goal of the service. However, it is perceived to be more like the outcome of the service than to appear during the service. In other words, responsibility seems to be something that isn't needed or at least wanted to be taken during the service. During the service, the responsibility was seen more as an obligation of the professionals. It seemed that to these informants, the service represented on one hand a possibility to give the responsibility away and on the other hand a process during which the responsibility was taught to them. The responsibility in the co-creation of the service seemed to be accepted if it could be considered something that should be taken in future but not at the time when they recognized to be in the need of the service. Current it was perceived to be when they had received enough information and felt that they could take the responsibility.

4.3 What is then the customership in mental health services?

In this part, the findings of this study are discussed focusing to the context of the study, internet therapies. The purpose of this part, thus, is to focus on the perceptions recarding internet therapies. Because these perceptions are highly context-specific as their nature, their external validity is as well low. Thus, consciously no referring to emerging theories is made in this part.

4.3.1 Negotiation of the role of a mental health customer: service as three step process

When discussing the perceptions about therapy as a service and being a customer in it, the informants portrayed quite similar pattern, that resembled a journey. The working mechanism of the journey was perceived as a process, during which the responsibility was at the beginning given to the service provider. After the customer had acquired enough knowledge the responsibility was returned to her / him.

In the narratives reoccurred an idea, that in the beginning of the disorder, the service was hoped to receive the most. Things that the interviewees mentioned they would wish for the service were: to be

met as a person, a feeling of being taken care of and help to solve the situation, in which the emotions and daily routines were seen to be overwhelming. Paradoxically, the informants repeated a notion that would want to be able to take care of themselves. At the same time, however, they wished that they could release the burden of responsibility for a while.

In the time of getting the disorder. The things hoped to receive from the service can be seen to distribute to help with emotions and help with concrete tasks. Help with emotions could not be listed as tasks but more as a phenomenon, which is portrayed in this narrative of Iiris' s:

> *Iiris: In the beginning of the treatment, you are taken care of, and you don't have to take care of things yourself. With my own problems, I specifically needed someone to take care of me, which means that I wanted someone to show me that they can carry me. I was not ready to take responsibility of myself at that point, because my views of the future were frightful and pessimistic. It was a cry for help, please, someone help me, take care of me. So, I needed attention, but also someone to take care of me.*

The help with concrete tasks was described as help to coordinate in the network of mental health services, like to find a source of help. The need is portrayed in this narrative of Nella's, in which she explains how she normally considers herself to have *"a control of my life, I have willpower, I like to find out things for myself, I have a university degree and on top of that, I have my friends and family who support me",* but during time of getting the disorder she would have wished for coordination and even mild patronage.

> *Nella: If someone just asks a few things, this sounds horrible, but if someone looks after you and makes sure you do it. In a way, it's not like that in any other situation, and if the situation changes, someone will be constantly watching you and looking after you, so you get an outsider's opinion, if you don't see any change in your situation, because you're quite alone.*

This account of Nella's portrays, that there are different needs for the service and that they vary in different phases of the disorder. As becomes apparent in the narratives of Iiris' s and Nella' s, at the time of the service need, they were tired and vulnerable. At that time, both Nella and Iiris found themselves to be more in a need of taking care of than in a need to experience a high level of autonomy. Moreover, both also portray, how they evade the idea of taking the responsibility and to being active at the same time they perceived that they were in the need of the service. These narratives portray,

how the service need is perceived to be in that part, in which the disorder is recognized. Also, the services seemed to be perceived to help in a difficult situation and not to be used without a acute need.

During the service: Teaching and learning. In all of the narratives, the key purpose in attending to the service was perceived to be the learning of the skills to manage with their situation in a way, that they could attend well balanced to their daily routines. Their objectives were linked to their ability to work and maintain social relationships. For example, Annika, Nella and Jasmina mentioned, that they wished to receive their ability to work similar to the state that it had been before the problems started to appear. Sanna then again wished that she would get over from the worst panic attack symptoms so that she could fully attend school and to go to activities with her child. Similar were the goals of other informants: less physical and mental symptoms, skill to raise mental health functional ability and ways to solve problems and difficult situations. Moreover, all the informants embodied that attending the service was temporary. After receiving enough knowledge and information they would cope without the service, like becomes apparent in this account of Iiris' s:

> *Iiris: I think the people taking care of your treatment have to have it at least in many situations, and when the patient is ready to take responsibility, has enough information and support, only then I believe that you have to take responsibility to be able to move forward.*

Like Iiris explains in her account, the human involvement was an initial issue in this part of the service. She portrays, how the responsibility should be given away at some level to be able to recover. That idea recurs throughout the narratives. Also, recurs an idea that people cannot be replaced by anything in mental health services. Although, the digitalization was not perceived as problem, this also shows, how in some services the human being is not that easy to replace with technology.

The outcome of the service. In the last phase of the service, the responsibility was transferred back to the customers. At the same time, the need for the service was perceived to end. Proper timing to transfer the responsibility back to customer was seen to be dependent on the progress in the treatment and on the state of mental health. In the narratives, it become apparent that the right time to the transfer was difficult to define. Also, most of the informants pointed out, that the right time could not set before the process had begun. Some opinions of the right timing were although given. For example, Sanna suggested that the timing to end the service would be right when the symptoms of the customer had remarkably decreased and the customer at least a little believes, that she can take care of herself.

To conclude, the service sounded to be perceived like journey towards learning: from taken care of towards achievable activity and responsibility of one's life. As seen in the narratives, the service was seen as a way for the patient to become a customer, an active actor, who could take the responsibility of his / her health. The services for mental health were clearly situated to the part, in which the patient was inactive. No need for mental health services was recognized for active actors. Service was located in the time of illness and perceived as a process during which the responsibility could be learned.

4.3.2 Perceptions towards being a customer in internet therapies

Before understanding the perceptions towards internet therapies, few pre-conceptions of the interviewees must be brought out. Thus, perceptions that are represented in this single paragraph, represent that perceptions that the interviewees had before the researcher had explained the idea of internet therapies to them. The concept of internet therapies was unfamiliar to all the informants. The interviewees thought that internet therapies equal psychotherapies, only with a difference that the appointment is actualized by digital manners. Moreover, four of the informants portrayed the applying process to be similar to process of seeking psychotherapist. Interestingly, five of the informants however reported that they had heard about internet therapies at least once. Another phenomenon that reoccurred in the narratives was that the informants had problems to separate the concept of internet therapies from social media platforms or from "other public English self-help platforms". Internet therapies were also thought to include video meetings, group therapies, online chat option and phone connection. Only one could portray quite realistic vision of the service. From these grounds the respondents also perceived their potential role as a customer of internet therapies. The following perceptions, if not otherwise mentioned, represent how the informants perceived the service after they were told the idea of it. Three different topics are discussed in this section: timing, target and responsibility. These topics are further compared with the perceptions of the service provider.

Timing. All the respondents would locate internet therapies to the end of the service journey, not as the first service option to someone who was recognizing first mental health symptoms. These opinions were based on the perceptions that internet therapies seemed to require motivation, will to recover and understanding of one's situation. Three of the informants also brought out that they had an impression, that in general, therapies as a word refer to end process of the treatment of mental health disorder. Therapy was not perceived as option to people who were recognizing the first symptoms of mental health disorder. Iiris portrays, that that time is a crisis itself for the patient. She also adds, that at that time, the patient would be at his / her wits ends, which would come across as

unbelief for the effectiveness of therapy work and as inability to commitment to it. Thus, therapy was perceived to be actual, when the person's functional ability is adequate to deal with the mental issues. That ability was perceived to be achieved during the service, when the patient learns about the nature of the illness and the its negative effects to life.

The perceptions concerning the timing were based on fact, that internet therapies were perceived to require too much activity and autonomy from the patient. In the narratives, that was argued mainly by two reasons: the assignments that the service includes were perceived as an exhausting idea. Secondly, as exhausting was seen the fact that the customer was in responsible of attending to therapy sessions alone. For example, Annika noted that if internet therapies included a need for produce any written text, she would see them as an suitable service option at the time the customer had somewhat empowered. Also, Nella shared a similar impression by assuming that doing assignments would require good self-reflection skills, that people with mental health issues usually lacked. She further argued, that she perceived mental health problems to include exhaustion and a lowered initiative, which would complicate doing the tasks alone. The situation to which internet therapy was seen as ideal is explained in this account of Nella.

> *Nella: So, if we imagine a hypothetical situation that there's a person who has had these kind of symptoms and the treatment has been successful, but they would still want something more. Like how I would see it for myself, maybe when the worst is behind me, and I'm in remission, I don't want to be completely cut out of all treatment after such an intensive period of it. I need that support, and if you think of it as a maintaining period, it's similar, so you'd always get an evaluation of your situation after a certain period of time, so it would support the individual's empowerment, so in a way, it's support for taking care of yourself.*

Like becomes apparent in this account of Nella, internet therapies were perceived as optional extra service for mental health issues and not equal to how the term service was understood. The narrative of Nella's also portrays the overall phenomenon that internet therapies were understood as therapy and not as mental health service. To the interviewees, the term therapy seemed to symbolize something different than the term mental health services did. Also, it seemed that the purpose of these two different concepts was perceived to differ from each other. Mental health service was perceived as service for being taken care of and therapy as service to empower people, who had already gone through the service process. Thus, in the service journey portrayed at the previous section (4.3.1), the need for services was located to the phases of getting the disorder and to the learning process during

the service. Instead, the need for therapy, and thus also the need for internet therapy was located to the outcome phase of the journey, due to which the need for the service would end. However, in this research, internet therapies were discussed as mental health service option. In order to gain understanding of the difference between the mental health service and the therapy concepts, more research needs to be conducted.

To compare to the perceptions of the service provider representatives, a difference in perceiving the timing was found. Waltteri, other of the representatives, portrayed internet therapies to be actual when the customer finds herself / himself thinking whether everything is alright with her / her mental state. He explained, that they recognized the problems portrayed in the narratives of the interviewees', but that these thoughts are part of the disorder. He further explained that an early intervention was suggested and that they as service provider perceive that taking care of mental health is as natural as taking care of physical health. He also explained, that internet therapies were to provide firsthand information about mental health problems, and that at the end of the treatment, that kind of information should already be familiar to the patient.

Target. Before explaining the idea of internet therapies, the interviewees suggested internet therapies to be targeted to people, who could not leave their home because of physical and mental barriers. For example, Sanna and Osku suggested that internet therapies were targeted to people with severe panic disorders or social anxiety. Comparative, Annika suggested that internet therapies were targeted to people that were tough but lonely and had no social safety net. Also, people with hectic job or small children were mentioned.

After the informants were explained the idea of internet therapies, they were perceived to help someone, who had almost recovered and longed for independency and routine to the daily routines. Osku also mentioned, that internet therapies sounded suitable to handle single life problems, like divorce, although he thought that they were not enough to treat mental health problems. When asked, the informants moreover brought out that they would hope that internet therapies could be utilized as a service for preventive mental health care. However, as it has become apparent, the informants also felt that the culture of preventive mental health care services sounded utopian and did not exist. The perceptions of the target customer are well portrayed in this account of Annika's.

> *Annika: I would say that the bar for seeking help, I think the bar is quite high. I've never before had burn out and I've never had depression. So, let's just say that the bar is quite high to seek*

help when your illness is still not so bad. Like usually you just think that it will get better if you rest over the weekend, like that is how the symptoms will disappear, but at that point, let's say, if there had been some sort of education about it, like for example at the workplace, if there had been some early stage support and if I'd got some education through that support, the bar would have been lower. We have good healthcare system at work, so the bar to get help from there is low, so it's not completely useless or inefficient, but I would need like an information package that I could identify the burn out symptoms myself, and I wouldn't think they're nothing and more information means more awareness and you'd probably be able to get some help and then if you were sent to that kind of internet therapy from there.

Moreover, the target was perceived to be a person without a diagnosis. Only two of the respondents knew beforehand that the diagnosis would be required to get into the internet therapies. Some of the informants responded to the information quite neutrally, but also disbelief was proposed. For example, Annika argued that she had an impression that a diagnosis could be set only after a person had already attended to some form of a health service. Nella further argued that she things that a person with diagnosis would already be too sick to attend to independent therapy work. That becomes apparent in this account of Nella, in which she discusses whether internet therapies would be a suitable service for someone who was recognizing the first symptoms of mental health illness and pondering whether he / she should seek for help.

Nella: Noo! Then, if you think about preventive measures, the diagnosis isn't the main thing, and if the person has a feeling and then wants to seek help. I'd say you don't need a diagnosis, because then the bar is higher again, so it doesn't work like that.

When discussing internet therapies as potential option to their situation, all the informants who compared the four different service options discussed previously, though that internet therapies would be suitable them in the future but not at the moment. For example, Annika argued, that at the moment, when she was returning back to work from her sick leave, the need for return assignments or set timetable to attend therapy on her own, would increase her anxiety and she would not accomplish the therapy. She also continued, that that in her case, internet therapies would not either have been an option at the time she recognized being exhausted because back then she was already too sick. However, when the interviewees were asked to imagine a situation, in which their choices were either medicine, internet therapy or no mental health service at all, all but one told that they would prefer internet therapies.

To compare to the perceptions between interviewees and the service provider representatives, a little less difference was found. Charles, the other representative argued that the internet therapies are targeted to a person who wants to take care of her / his health and recognizes to be willing to work for that goal. Waltteri, however, continues that internet therapies require good level of working ability and acceptance towards independent therapy work. What was clearly different in the perceptions was the fact how the diagnosis was perceived. The representatives of the service did neither see diagnosis similar as the informants did. Waltteri explained, that he thinks that the diagnosis do not tell anything about the person who is diagnosed. Instead, he sees it as working tool for health care personnel. Informants instead explained that diagnosis equals risk of being stigmatized and that asking a referral to psychiatric who would set the diagnosis would demand a lot.

The level of human involvement and responsibility. Like presented in the part 4.2. the level of human attendance and the feeling of responsibility were the main factors effecting to the perceptions of the service quality. At this part of the analysis, these perceptions are discussed in the context of internet therapies.

As explained, the informants perceived that mental health services were to serve as the process of giving away and receiving the responsibility of one's mental health. That image did not fit to the image that the informants had about internet therapies. As a metaphor, one of the respondents compared internet therapies to sound similar to carrying a correspondence. In general, internet therapies were not perceived serve to same needs that the mental health service was perceived to serve, because the communication was possible only through writing. The opinions, weather the responsibility could be given away through digital connection at all, varied. The informants shared a perception that in the service, in which no voice or video connection to the therapist was available, the responsibility could not be given away at adequate level. Three of the respondents, however, were positive to the idea that through at least voice connection, the responsibility could be given away. In general, the more the level of human involvement got lower, the less possible the transferring of the responsibility was perceived to be.

In the perceptions of internet therapies, responsibility seemed to be associated with the need to attend the sessions independently and to conduct any exercises. In the conversations, the perceptions of the responsibility were continuously explained through the assignments. That feature of the responsibility

responsibility experience seemed also to be the main reason for negative associations and doubt towards internet therapies in general. These perceptions become apparent in this Nella's account.

> *Nella: So, I don't see that if I'm burnt out and anxious and if I have symptoms like that, if a list of questions is shoved in front of me, like questions asking me to think about my values or stuff like that. It might be too much, I think I'd have to first just spit out what I'm feeling.*

Like is apparent in this quote, Nella explains how the idea of any task or assignments felt too much asked. Notable is that the topic of responsibility was perceived differently by the service provider. To compare, Waltteri argued that already part of the responsibility will be given away when the patient decides not to cope alone and seeks for help. He also argued that, although the therapist was separated from the customer, the therapist was there to give trust and new perceptions to the situation. From their experience, Waltteri and Charles both argue, that the autonomy in the therapy is sometimes perceived to be scary but during internet therapies, the customers have not experienced that as a problem in the most of the cases. Waltteri further argues that, in group level, the results of the effectiveness of internet therapies are high and hardly no one perceives the service to decrease their condition. Thus, he further argues that especially when the need for mental health services is not properly met in Finland, people should give a chance to the internet therapies.

5 DISCUSSION

The findings of this research increase our understanding on how consumers perceive themselves as customers for self-guided online services in the context of mental health. The findings are related to understanding how consumers build their understanding of mental health services as potential consumptionscape and how they would perceive their role as consumer in this servicescape. The findings of this research are twofold and have both convergence and divergence with the emerging literature. In this chapter, the two main findings of this research are further discussed.

5.1 The role of mental health in the discourse of health consumptionscape

Firstly, the findings rely heavily on the literature, that shows the tremendous change of health culture, consumption and consumers' role in health services (e.g. Askergaard & Schneider-Kamp, 2019; Kristensen et al. 2016; Ayo, 2012). In this research, the change is clearly recognized, and the consumers do not question themselves to be part of these markets. However, the findings also show that the rules and norms of these health services markets are not perceived to exist in the area of

mental health. Instead, using mental health services seems to be something that is not in accordance with accepted standard and rules of consuming. That finding is in contrast with the literature emphasizing the empowering potential of digitalization to mental health consumers (e.g. O'Cathain et al. 2005; Newman et al. 2015). In general, this study finds, that the things that are associated to consumable health services mainly equal to things, that this research recognizes to be perceived as problems in mental health services. The first main finding of this research hence suggests, that there are perceived to be a crucial difference between these two digital health consuming cultures. Moreover, this research suggests that digitalization is not the main reason to explain this phenomenon. Thus, I also suggest, that the phenomenon would not possibly vanish although the, e.g. the problems recognized in technological acceptance of digitalization, would be erased. This finding is discussed below from two different perspectives.

5.1.1 Category illigitimation of mental health consumption

In the findings of this study, the modernization of health services, and the increased importance of digital health care systems (e.g. Askergaad & Schneider-Kamp, 2019; Kristensen et al. 2016; Ekeland & Bowes, 2010) were both recognized to exist. Also, the commodification of the markets, and the idea that health consumers equal to the neoliberal assumptions of responsible and entrepreneurial citizens, motivated to consume on their health (e.g. Ayo, 2012, Crawford, 2006), were both recognized as requirements for nowadays' citizens. However, these trends were found to exist in other contexts of health, but not in mental health services. In mental health care services, on one hand the attempt to modernize the services through digitalization (e.g. Newman et al. 2015) was recognized. On the other hand, however, the consuming assumptions in other forms of health services were not perceived to apply to the users of mental health services. In the light of the emerging literature, the factors of consumable health services, such patient control, patient participation, motivation, ability and patient autonomy (Askegaard & Schneider-Kamp, 2019; Ouschan et al. 2000; Funagalli et al. 2015) were also perceived as things that were insufficient or unclear in the mental health services. Thus, this study suggests, that there are perceived to be insufficient agency and unclear customer subjectivity in mental health consumption.

The findings are in contrast with current literature that argues for the empowering power and potential of digitalized mental health services in order to, for example, serve new customer segments and to lower the access to treatment (e.g. Barak & Grohol, 2011; Musiat et al. 2014). Instead, this research shows, that these expectations, that are set to other forms health consuming, are perceived not to be applicable to mental health consuming. Firstly, that is explained as lack of the characteristics, that are

usually perceived to belong to consuming of services: consumer agency and the positive emotions. In this research, the lack of these characteristics was also the reason why the self-guided digital mental health services were not perceived to respond to consumers' needs. That makes me suggest, that the concept of consumable service is not what the mental health consumers currently wish for their mental health service.

Secondly, this research shows that there is no recognizable consumer culture around mental health. Instead, the cultural orientation towards mental health services seems to be in contrast with the features that portray the modernization of health care culture. For example, the findings are in contrast to the findings of e.g. Kristensen et al. (2016), who argue that the exchange in health markets has turned to resemble objectified and standardized market process, in which individuals can control their purchase. Neither the findings are in line with the findings that emphasis the potential of laymen as source of health knowledge (e.g. Fox & Ward, 2006; Burrows et al. 2000). Instead, according to this research, the authority of the professionals in mental health were perceived high. That finding is interesting in the light of the finding of Prigge et al. (2015), who argue that the acceptance of physician authority affects negatively to patient empowerment.

Moreover, this study shows that consuming of mental health is perceived to be socially unsuitable. Instead, it is perceived to be something abnormal when comparing it to other forms of health consuming. The findings show, that there are problems to recognize being a potential customer for mental health services. Instead, in other forms of health services, consuming was seen to be the almost admirable. This finding relates to finding of Cavusoglu & Demir-Kaplan (2017), who found out that most of the health associations were represented in categories with bodily dimension and not in the spiritual categories, to which the feelings belonged. This research also finds, that the consuming of mental health was not wanted to be socially shared. It was rather wanted to keep as secret, limited to the knowledge of the core actors in the services: the service personnel and the customer. This set of findings rely on findings arguing for stigmatization around mental health (e.g. Corrigan, 2004).

In this specific research context, the findings suggest that there is a potential crush in the perceptions of the services providers and the consumers, that are not currently users of mental health services. That was apparent the most in perception towards the timing of the service needed: the service provider shared an idea that the mental health can be considered to be taken care of similarly actively than physical health. The potential consumers, however, did not recognize that as a possibility. Instead, they shared an idea that people are not motivated to consume for mental health voluntarily.

Moreover, they shared an idea that people cannot recognize the state of an occurring disorder and that is why the early prevention is impossible. These findings rely with current literature that emphasis the dependence of the context of the diseases and consumer behavior (e.g. Prigge et.al 2015; Robert & Macdonald, 2017). Moreover, these findings also rely on notion, that in order to meet the customers' perception of value in the service, context and characteristic of different disorders must be similarly taken into account (e.g. Porter, 2010; Cowden & Singh, 2007). The findings suggest, that many of the specialties of the health services, like vulnerability, dependency, stigma and ambivalence to consume (e.g. Robert & Macdonald, 2017; Berry & Bendapudi, 2007) are underlined in the mental health sector. Hence, the findings add support to this current literature arguing on how context-dependency and the differences between consumer types must be taken into account when considering customers' role and capabilities in these services.

5.1.2 Digitalization is not the problem in the modernization of mental health care?

What it comes to the digitalization of health care services, the findings of this research are in line with the research recognizing that digitalization has increased possibilities and changed roles of actors of online environments (e.g. Lupton, 2013; Fox & Ward, 2006). The findings of this study show that digitalization is seen as possibility to be utilized in mental health too. Online service options were found to consist many possibilities, like lack of physical transitions, that the traditional forms of services did not offer. Online services were also seen to symbolize something modern and to potentially lower the level to start using the services. In this research, the usability of digital devices was not questioned in general.

Also, the findings of this research relate in some level to the current literature, that emphasize the empowering nature of online services to consumers (e.g. Andreassen et al, 2006; Parkinson et al. 2017). However, in some level the findings also do not resonate that view. In this study, the trend of customer empowerment was perceived to be possible mainly in the back-end of the treatments. In that phase of the services, consumers could see the service to help them in taking active role and to help in building routine to take care of their mental health, pretty similarly that e.g. Fox & Ward (2006) find that digitalization can effect on how consumers take roles in services. Notable also is, that the findings of this study did not find any support for anti-consumers' behavior or resistance towards authority of medicine, that e.g. the findings of Fox & Ward (2006) show that online environment can cause. However, these findings are in line with the findings of Newman et al. (2015) who argue that problems in empowering effects of mental health services still exist.

Like explained, that kind of potentially empowering effect of digital mental health services was perceived to be possible only in the back-end of the services. The back-end of the service, was also perceived as the part of the service journey, in which customer is already preparing to finish using the service. At that time, the need for the service was perceived to have decreased significantly. The most urgent the need for the service was perceived to be at the early phase of disorder. At that time, the consumers rather portrayed themselves to be vulnerable than easily to be empowered. At that time, the digitalization as a feature of the service was not perceived to be a negative thing. However, the more the service was digitalized, the more the service quality was perceived to decrease. Moreover, the service delivery was perceived to be possible only as long as not too many senses were removed from the communication between the customer and service provider. In services with video and/or voice connection the delivery of the most important features of the service was perceived at least adequate. The unwillingness to use digital services appeared not only these ways of connection were deleted. However, this finding seems to be linked in mental health services because in many other forms of services the lack of voice or video connection was not perceived as problem. Hence, these findings relate to findings suggesting that digital services may cause burden of invisible work and self-care (e.g. Lupton, 2013), and feeling of being overwhelmed to confront the illness (Nicolini, 2007). This study suggests, that these phenomena might be experienced also among mental health users. In line with these findings of the literature, this research also shows that these experiences lead easily to avoidance of the service.

The most importantly, this research suggests, that the digitalization of mental health services is not the key to explain why the digital services were not perceived as consumable practice. Instead, the study suggests, that the factors explaining whether the consumers could perceive themselves as customers of these services were the level of human attendance during the service and the amount of responsibility experienced in the service. The level of the service was perceived to get worse as the level of responsibility increased, and the evolvement of human decreased. These barriers to use the service were seen to be possible to exists in some level in all forms of mental health services, but they were seen to be significantly more emphasized in digital than in physical environments. In this research, these factors were explained by negative emotions, like fright, guilty, powerlessness and incapability. At the beginning of the service, these factors were perceived to complicate the service use the most. The findings of this study show, that the negative feelings perceived, were turned into experience, that too much was required from the customers in the service. Moreover, the findings show that it is unclear to consumers, whether the responsibility of taking care of the treatment belonged to customer or to service provider. These findings relate to notion of Elms and Tinson

(2012), who found out that although the online environment could change the sources vulnerability, they it did not significantly decrease or remove them.

As the first main finding of this research, I suggest that there exist two different contexts of digital health consuming. Also, I further argue that this phenomenon cannot be fully explained by digitalization or digital features of the services. This research, however, does not provide understanding to further understand either the nature, limits or contents of these two contexts. Hence, more research is needed in order to define these contexts more. However, the findings of this research provide understanding to argue, that at least two different contexts exist: one in which many forms of health services are perceived to be included, and another one, in which mental health services are perceived to included. That is argued because according to this research, the rules of consuming, perceived to apply when consuming health services, are not seen to concern mental health services. In other words, it seems that mental health is perceived as illegitimate category of consumption. Thus, it also seems, that there is lack of customer subjectivity in mental health. This finding might however appear only in this specific research context and might be explained for example by cultural features or period of time. Hence, more research is needed to see whether the polarization is socially shared or stable as a phenomenon or whether it is a part of a progress, as a result of which consuming of mental health services are turning in to resemble the other health services. However, at the moment it seems that there are at least different types of consuming types in the field of health care services. To serve all these consumers, different approached are needed. Moreover, this research suggests that the same approaches that are applied to other health services are not similarly applicable to mental health services.

5.2 Digital mental health services disempower customers?

Secondly, in line with the first argument, the findings of this research do not relate to the current literature, that emphasises the empowering potential of digital services (e.g. O'Cathain et al. 2005; Chatzimarkis, 2010; Prigge et al. 2015), and their possibility to serve new, previously underserved health care customers (e.g. McColl-Kennedy et al. 2012). Instead, the findings of this research support the findings, that argue for context specialty of disorders and the specialties of mental health sector consumers' (e.g. Fox & Ward, 2006; O'Cathain et al. 2005; Spencer, 2014; Schulz & Nakamoto, 2013). These findings are further argued with another main findings of this research: it seems, that consumers perceive themselves likely to adopt consumer coping strategies that are portrayed in the literature of vulnerable consuming (e.g. Adkins & Ozanne, 2005; Duhacheck, 2005; Echeverri & Salomonsson, 2019). Thus, they also perceive themselves not likely to employ behavior strategies,

that are portrayed in the current literature explaining how consumer may, for example, take new roles through empowerment (e.g. Ayo, 2012; Crawford, 2006; Kristenssen et al. 2016). This finding is discussed from two different perspectives below.

5.2.1 During the Mental Health Service is needed: Emotions explain vulnerability

This research shows that there are consumers, that are currently without proper treatment and perceive themselves to be in a need of mental health services. In principle, digital services are seen as service options among others therapy or outpatient services. The findings also show, that the need for the service is placed to the time, when the consumers perceive themselves to be in the early or in otherwise challenging phase of their disorder. At that time, the consumers wish the service to give them for example experience to be met by another human, someone to share their burden, feeling of being taken care of and concrete help with their feelings and daily routines. If these needs, that are from now on termed as the primary needs, were perceived to been met properly, the purpose of the service was perceived to change. Next, the following purpose of the service was perceived to be to teach informants to cope with their disorder. However, this is more discussed in the following chapter.

However, if these primary needs were not met, the consumers perceived the quality of the service to be low. As a consequence of that, their unwillingness to use the service grew. Especially, digital services were perceived to prevent the delivering of these primary needs, if too many senses were removed from the communication between the service provider and the consumer. Furthermore, the findings show, that the inability to meet the primary needs led to emotions, like fear, guilty, powerlessness and incapability, that again easily led to experience of too much autonomy is demanded from them. That relates to the findings Lupton (2013) and Nicolini (2007), who argue that digital services may cause burden of invisible work and self-care and the feeling of being overwhelmed to confront the illness. Also, this finding relates to the finding of O'Cathain et al. (2005), who argue that people who are experiencing pain, ill or negative feelings might value more being cared of than being empowered.

These negative emotions experienced, were portrayed to easily lead to behavior including avoision, freezing, denial or playing the victim. This kind of behavior is in line with coping strategies in the current literature. For example, the findings seem to equal to limited coping skills and to narrowing of the social interactions, that were defined to be typical for social isolates in the categorization by Adkins & Ozanne (2005). Also, the background reasons for vulnerability were found to equal to findings made in current literature of vulnerable consumption (e.g. Falcetti et a. 2016; Adkins &

Ozanne, 2005; Echeverri and Salomonsson, 2019). Moreover, this study found out, that this kind of vulnerability was perceived to exist only in the area of the emotions and especially during the mental health services use. Namely, the findings show, that at the same time the consumers could perceive themselves as fully competent in many other forms of consuming. This finding heavily relates to the finding of e.g. Baker et al. (2005), who argues that vulnerability can be experienced by anyone in market related context.

Thus, the findings of this study also show, that at the time of the service need was perceived to exist, hardly possibilities to empowered behavior was found (e.g. O'Cathain et al. 2005; Chatzimarkis, 2010; Prigge et al. 2015). Instead, the findings of this study show, that consumers, for example, perceived the total self-coordination or self-education impossible in mental health services. The more the experience of autonomy increased, and the level of human attendance decreased, the more negative were the perceptions. In some level, these findings would explain also the finding of Gammin et al. (2014) who argue that especially the mental health culture, the consumers would need assistance and proactive encouragement to benefit from the self-creation possibilities of technology. Based on these findings, this research firstly suggests that consumers perceive primary and secondary needs to mental health services. Secondly, this research suggests that in the digital forms of mental health services, especially the primary needs were perceived to be difficult to fill up – if the level of digitalization was perceived to exceed the specific level. The findings of this study suggest, that in this scenario, the vulnerability made the secondary goal, learning to cope with the disorder, impossible. I also suggest, that this may partly explain the negative perceptions towards digital mental health services. The findings can also be interpreted so, that at the beginning of using mental health service, the purpose was to let go of the responsibility, not to take it. Only after that, the learning process could begin.

5.2.2 Empowerment is the desirable goal and the service is hoped to teach how to reach it

The secondary purpose, the perceived goal of attending to a mental health service, was found to be the learning of skills to manage emotions and life situations in a way that well balanced daily life, expected from people in general, would become possible. To teach these skills, was seen as a duty of the service personnel. Thus, the service personnel were also perceived as the actor who possessed a status and communication skills to teach them. Moreover, the learning was not perceived to became possible until the primary needs were met. Also, notable is that the consumers perceived the need of the service to be temporary and no continuous care from the service was expected. The desired goal thus seemed to be a status of being healthy and independent. This relates to findings of the ideality,

for example, of healthism culture and consumers that are able to monitor their health status (e.g. Ayo, 2012; Crawford, 2006). The knowledge gained from mental health service was seen as a key to empowerment. However, the possibility for empowerment was not located to time, in which the service need was perceived to be the highest.

The findings also show, that irrationally, the status of being healthy and independent was also tried to be reached already when starting the service use. In the findings, it appeared as willingness to be independent actor in the service simultaneously to the experience of being vulnerable. This finding is in line with findings, that found vulnerable consumers to be driven by conflicting feelings: willing to be independent and being dependent at the same time (e.g. Adkins & Ozanne, 2005; Echeverri & Salomonson, 2019). Also, this relates to the finding of Baker et al. (2001), who explain, why vulnerability and independent behavior might exist at the marketplace at the same time. Moreover, the findings suggest, that that the willingness to be independent was also one of the reasons that would lead to coping behavior such service avoidance. That is supported by the current literature on vulnerable consumer behavior, that shows, that the experience of being vulnerable might be perceived embarrassing (e.g. Adkins & Ozanne, 2005; Echeverri & Salomonson, 2019).

As another main finding of this research, I argue that the consumers seem to have primary and secondary needs, and that the mental health services, regardless of the form, are seen as a service to fill up these needs. Also, these needs seem to be partly contradictory and to appear limitedly. Moreover, the findings of this research add that digitalization, in it's some versions, is perceived to prevent the fulfillment the primary goals. The findings of this research also show that during the most urgent need for the service, the consumers are likely to use coping strategies rather than strategies that are recognized to be typical to empowering services. Furthermore, the findings show, that all this is something very opposite to how they perceive themselves as consumers in other fields of health services. Lastly, this study finds out that the empowering potential of the service was perceived to be possible at the back-end of the treatment, if the primary needs were already fulfilled. Thus, this research suggests that consumers perceive digitalized mental health services as possibility to serve the secondary needs. Instead, until the primary needs are met, they perceive the services as rather disempowering than empowering. Notable however is that the empowering potential would also be located to the time when the need for mental health service was perceived to be ending.

These findings raise a question, whether the consuming of mental health services would continue at all when the consumers have reached the goal of being healthy and independent, i.e. empowered? If

yes, in what kind of mental health services? In other words, what kind of would be a mental health service, that the consumers would use when they do not perceive their problem to be acute or impossible to be solved alone? That question is important in order to evaluate how the possible empowering potential of mental health services could be utilized to meet the needs of the customers. In the current literature, the closest option, that I found to resonate to that kind of consumption, would be the dimension of feelings in the discourse of health, portrayed by Cavusoglu & Demir-Kaplan (2017). They namely recognize feelings as a dimension of health discourse, referring to forms of health that were associated on positive feelings, spirituality and inner peace. However, more research is needed to find out whether this dimension would be associated to mental health care at all. Secondly, open in this research was left a question, whether some kind of the mental health service would be perceived as potential at the time before the primary needs appear? That can be raised as a question because this research shows that during that time, the consumers did not recognize any need for using the service. However, they also argued that this unwillingness was caused by the irrationality of the idea and lack of knowledge on the symptoms of mental disorders. The informants also suggested, that if they would have understood that they were in a risk to get the disorder, they would have acted preventively. That makes me suggest that perhaps for example internet therapies that were perceived to require high level of autonomy from the user, would meet the needs of the customers as preventive services, i.e. at the time, consumers do not themselves recognize any need for service. However, more research is needed to understand, how and with what kind of communication, that kind of services could be proposed to consumers.

5.3 Theoretical implications

This study contributes to consumer behavior and services research literatures by expanding the understanding on consumers' perceptions of their role, and their behavior in self-guided digital health care services in the context of mental health care. Precisely, the findings of this study contribute to understanding on the phenomena of current health discourse, consumer empowerment and consumer vulnerability in the context of health services.

This research confirmed that consumers experience the change of health culture and the presence of the novel, consumer centered health culture which, for example, Askergaard & Schneider-Kamp (2019), Ayo (2012) and Kristensen et al. (2016) present in emerging literature. This research also confirmed e.g. the notions of, for example, Lupton (2013), Nicolini (2007) and Oudshoorn (2011) who argue that these phenomena are perceived to cause not only positive but also negative effects to consumers. In contrast to this literature, this study presents that these phenomena are not perceived

to be applicable to mental health services. Instead, that kind of behavior, that the current literature portrays (e.g. Ayo, 2012, Crawford, 2006, Kristensen et al. 2016) is understood to exist only in certain health context. Furthermore, this study completes this literature proposing that currently, the literature does not reach the essence of health care services diversely enough. Namely, this study shows, that there are perceived to exist at least two concepts of digital health consuming. To the current literature, that could be suggested for example as re-evaluation of the discourses of health, proposed by Cavusoglu & Demirbag-Kaplan (2017), to examine whether mental health could be perceived to fit to this conceptualisation or weather is it perceived as something else than health in that manner that Cavusoglu & Demirbag-Kaplan (2017) portray.

This research also uncovered the drivers and consequences of health care customers' behavior in the context of digital mental health services. Thus, this study confirms several ideas presented in the literature of vulnerable consumer behavior (see e.g. Adkins & Ozanne, 2005; Echeverri and Salomonson, 2019). This study confirms as well several ideas that are represented in the literature proposing the disempowering effect of health services to some customers (see e.g. Nicolini, 2007; Oudshoorn, 2011). Moreover, the findings of this study support the notion of Cowden & Singh (2007) and Porter (2010), who argue that in health services there are still several problems to meet the interests of consumers. At the same time, the findings of this research are in contrast with the current idea of the literature that emphasises the empowering possibilities of digital services to health consumers in general (see e.g. Lupton, 2016); Andreassen et al. 2006). To these theoretical notions, this research provides more understanding about how the needs of mental health consumers, which can be considered as one remarkable health consumer group, are not currently met in the digital service offerings. Moreover, this research suggests that different strategies to serve these consumers should be employed. Lastly, the findings of this research support the argument, that Taiminen and Sarajärvi (2018) have brought to conversation. They recall for more consideration on whether the current literature of the services acceptance in digital mental health services focuses too much to the aspect of technological acceptance and dismissesw the value aspects of consumers.

To conclude, this research widens our understanding of the knowledge, emotion and perceptions of mental health users about the health care services development and about digitalized mental health services. Precisely, this study widens that understanding among previously underserved consumer groups, to whom the digital options might ideally now provide services this contribution. This study made this contribution in Finnish health care services context. Thus, this research fulfills it' s objective that was set to contribution of the emerging literature.

5. 4 Limitations

As distinctive to all scientific research, this research is not free of limitations. In this research, especially two aspects of limitations need to be taken into account. Firstly, while being positioned towards an interpretivist research and choosing to examine individuals' personal experiences, the research findings cannot be generalized to analyze phenomena in wider contexts. This research explains the lived experiences and reflects the realities of these people that, in the end, consisted of relatively small sample. Bigger samples should be researched, and more longitudinal data collection should be made in order to generalize the findings to account, for example, to population level phenomena or to forecast development inside a nation.

Neither the role of the researcher cannot be disregarded. Although the researcher tried to be as objective as possible and to separate her personal experiences and knowledge from the data collection and analysis, interpretative phenomenological analysis makes it impossible not to include the interpretation of the researcher to the outcome. That is because, as stated, in building understanding, the researcher's access to the lived experience is limited to what she/he is told. Hence, analyzing the appearance of single experiences and their relation to bigger context, interpretation of the research is needed.

Secondly, the chosen context and the demographics of the informants set some limitations for this research. This research studies the phenomena of consumer perceptions and behavior in the context of digitalized mental health services, and further defined internet therapies. Thus, the findings are tied to this specific consumption context. As brought out, mental health as a subfield of health includes many special characteristics, like stigmatization and the vulnerability of the consumers. Hence, the result cannot be utilized to analyze health related service contexts that does not share the same characteristics. Notable also is, that all the informants were required through a webpage that was meant to be easily found when searching help for mental health problems. That shows that these informants already recognized their problem in some level and had already found their way to search information from digital environments. That might also show, that these people first of all were all highly computer literature.

Moreover, different findings may have done if similar research would have been conducted in for example consumer group that Annika told she had represented few months before her breakdown. In her account, Annika portrayed that at that time, while she had filled a routine questionnaire considering well-being at the work, she had made a joke of being in a risk of a fatigue but did not

believe that to come true in any level. The chosen informants also represented quite young people and most of them were highly educated and all (who shared information of their educational level) had at least upper secondary education. Most were also still attached to working life. They also shared an experience that they had tried to seek for help but had experienced that they had not gotten enough or proper help. Lastly, only one of the interviewees was a man. Conclusively, these people cannot be seen for example to speak for extremely socially marginalized or for elder consumer groups.

5.5 Managerial implications

This research provides useful perspectives to consider in businesses providing digitalized mental health services. In this section, two different aspects are brought out: services development and communication.

Services development. This research provides information of the differences between potential consumers' and service provider's perceptions, in the context of internet therapies. Also, this research shows, how consumers for these services consist of many different individuals with different service needs. This knowledge could be utilized for example in developing the service. Firstly, the development of the service could be seen as a way to scale the service to wider use. As the service is produced in digital environment, ability to flexible service modification might make the service suitable for many different consumer groups. In segmenting and targeting consumer groups, knowledge about different consumer needs or coping behavior among vulnerable consumers could be utilized. As this research shows, consumers have difficulty to perceive mental health services as similarly achievable services as they perceive other health services. That makes me question, whether the service could be utilized as more preventive health care option with different branding, like portraying the service to more as mentoring learning environment than as a therapy option.

Secondly, this research shows out that the consumers would perceive the digital services' as potential option in many different forms and phases of mental health services. This knowledge could be utilized also in considering current treatment options. As example, using of internet therapies in the end process of the service was supported in this research. That could be considered as a way to lower the costs of the current treatment programs in lightening the service from the back-end of the service journey. Also, this research shows that the consumers would perceive the current service to be better for their needs, if there would be a possibility to at least once video meeting. Thus, adding these features could make the service more attachable to potential customers. Lastly, because of the differences of current service perceptions, it can be suggested that all service development should be

made in near contacts with customers. Also, information about before and after service use perceptions should be continuously collected to better understand, how these perceptions change over service use.

Communication. The findings of this research speak for more direct guidance from the service provider. That is because people clearly lack knowledge regarding for example the usage, the target users and the access processes of internet therapies. In this research, I found out that people, for example, did not recognize themselves to be potential customers for the service. They also portrayed how the negative perceptions stem from, for example, the fear of being left alone, uncertainty of the amount of the responsibility. Also, they brought out, that these perceptions may arise from the fact that they cannot imagine e.g. being able to build treatment relationships through writing. This research shows that the consumers would perceive the current service to offer better quality, if more guidance to understand the user responsibilities would be available. That makes me suggest, that these negative emotions and perceptions could be eased with minimizing the uncertainty and as a consequence of that, the level to try out the service could be lowered.

Secondly, if the service is wanted to be utilized more as preventive or treatment to mild or occurring disorders, motivation and information sharing need to be better targeted to these consumer groups. That information should be shared in their own environments, like in workplaces or colleges – in places where the people still have good level of function ability left. I suggest, that targeted pilots should be utilized to develop the communication materials and to find out where different consumer groups would receive the information the best. This research suggests that e.g. information about the early symptoms, like the disbelief to be in a risk to get a mental health disorder, could help. In social-political perspective, this kind of information sharing could also have effect to political decision making, for example, in renewing health care services, or in altering general public attitudes, like attitudes regarding stigmatization or the state of which help for mental health symptoms can be sought.

5.6 Future research

Despite this research broadens understanding of consumers' perceptions towards their roles in the context of digital mental health services, room for more research is left to gain deeper understanding of the phenomena. Potential aspects to continue the research work are multiple. In this section I suggest two aspects, that this research showed to be in a need of more examination.

Firstly, this research shed light to our understanding how mental health consumers easily engage to coping behavior when they experience the pressure of too much responsibility and inadequate level of human attendance. Moreover, this research suggests that negative emotions are the main explanatory reason to this phenomenon. That can be seen as contrast to previous research that emphasises the empowerment potentiality of digital health services. Also, this research suggests that not all the consumers experience these services as empowering and thus, more research is needed to understand why some customers, in different value creation processes, respond to services disempowering while others respond empowering. That is not an aspect that should be disregarded however, because after all the digital health services may offer potentiality. That can be also argued because the emerging literature has focused remarkably to the technological aspect of digital services acceptance (Taiminen & Sarajärvi, 2018). This research supports the argument of Taiminen & Saraniemi (2018) who call for the research of service acceptance from the customer value perspective. I suggest, that this is needed to better understand the customer satisfaction in digital health services.

Secondly, the possible emotional background of the behavior should be more examined to understand the behavior. That can be argued because only through understanding different types of consumer behavior, different strategies to serve different customers can be developed. As a single example, the understanding on how the concept of autonomy is experienced in different value co-creation and self-creation processes could be utilized in many different service contexts. In addition, in the field of health care that can be argued to be extremely important, not only because of the costs of different disorders are causing to societies, but also for the sake of affirmative action in health services.

Thirdly, I suggest that the concept of health services under market exchange should be more examined. In this research, I made a finding that the expectations, that are perceived to concern health consumers in general, are not perceived to apply similarly to different health context. As a consequence of that, some fields of health are perceived as consumable while others are not. Although this research confirms that the existence of market orientation is recognized in health care, it also finds out that health is not a solid concept from the aspect of consuming. Further research should be conducted to understand the nature of this phenomena, for example, to understand differences and similarities, linkages and associations or causes and effects of different types of health concepts. Lastly, research should be continued in the same context than this research was made in. This study was conducted with limited customer sample and in order to confirm or generalize the findings of this research, research in different demographic contexts and with wider amount of data should be collected.

6 CONCLUSIONS

The field of health care services is changing fast and the future of it can be only envisioned. However, certain is that the significance of health services will not vanish. That is why, continuous attention is needed to stay focused on this corner stone of societies. The goal of this study was to participate in this discussion. The study has fulfilled its purpose by giving us an understanding of different customer perceptions and behaviour in the health service environment.

The aim of this research was to find out how underserved consumers of digital mental health services perceive the development of health services. Also, this study aimed to find out how these consumers would see their role as customers of these services. This research was contextualized to potential customership in internet therapies. The findings of this study show that, in general, consumers perceive consumption of health services as a paradox, in which two different kind of worlds are appearing on the market place. On one hand, consumers perceive that in many dimensions of health, the current trends in modernization of health services are in line with their understanding and knowledge. On the other hand, consumers also perceived that the rules of consumerism and were not applicable to mental health services. Instead, the customers possessed many negative emotions and perceptions towards the idea of consuming in mental health. Moreover, the customers perceived to have two different kind of needs for the service: primary and secondary needs. The digital services were perceived to complicate the fulfillment of the primary needs. However, the digital services were also seen potentially serve the consumers' secondary needs. Currently it seems that the needs of these consumers are not fully met in the marketplace, what it comes to the self-guided web-based mental health services. Hence, this study suggests, that consumers would withdraw and experience the services too exhausting and thus not contribute using the service. This study suggests that the consumers' experience stems from different perceptions between consumers and service provider actors. Comparing the perceptions of consumers to the ideas of the service prover, this study found that, in internet therapy contexts different perceptions appear in the target, timing and the level of human involvement and responsibility in the service. Moreover, this study finds that consumers have a lot misinformation regarding the digital mental health care services. However, more research is needed to continue to understand these phenomena more. To conclude, this study has fulfilled it' s aim and additionally contributed to the current literature by offering information of the perceptions of health care customers, among mental health consumers.

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